

Disability Rights

ARKANSAS



*Booneville Human Development Center
Administration Building*

**Bound to the Past:
The Excessive Use of Restraint at
Booneville Human Development Center
January 2016**

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Restraint at Booneville
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A public report by
Disability Rights Arkansas, Inc.
January 2016

Acknowledgements

Disability Rights Arkansas, Inc. (DRA) is the federally authorized and funded Protection and Advocacy System and Client Assistance Program for individuals with disabilities in Arkansas. DRA is authorized to protect the human, civil, and legal rights of all Arkansans with disabilities consistent with federal law.

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Introduction

The State of Arkansas operates five Human Development Centers (HDCs),¹ which are institutional facilities that provide 24-hour residential, medical, and habilitative services to individuals with developmental disabilities.² The five HDCs are located in Arkadelphia, Booneville, Conway, Jonesboro, and Warren. As of September 2015, 908 individuals with developmental disabilities reside in the State's HDCs.

Booneville HDC is the oldest property of the five HDCs. The facility is located in Logan County at the former site of the Arkansas Tuberculosis Sanatorium; it is a large facility on 900 acres with many buildings that are almost 100 years old.³ Booneville HDC has 138 licensed beds for residents and has approximately 300 employees. The facility's annual budget was \$16 million for Fiscal Year 2014; however, millions of additional dollars are needed to address the aging physical plant conditions at the facility.⁴

In January 2015, Disability Rights Arkansas (DRA) released a report expressing concerns regarding both the physical plant conditions and the high number of restraints at the facility.⁵ DRA recommended closure of Booneville HDC due to the conditions and the excessive use of restraint at the facility. These concerns are in addition to DRA's general concern that Arkansas continues to rely on restrictive institutional care for individuals with disabilities in violation of the integration mandate of the Americans with Disabilities Act as articulated by the United States Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999),⁶ while thousands of Arkansans are unable to access services that would allow them to live in their communities.⁷

There is controversy within the State about the continued existence of Booneville HDC, and there has been no movement toward closing the facility. Nevertheless, if the State continues to rely upon Booneville HDC for the care of individuals with developmental disabilities, it must take steps to ensure that the individuals who reside in the facility are free from the unnecessary use of restraint and have access to treatment that eliminates the need for restraint.

Since publication of our January 2015 report, DRA has continued to monitor and review the use of restraints at Booneville HDC. In an effort to evaluate the extent of the restraint activity, DRA reviewed all restraint reports for a sixteen month period and HDC reports, which are submitted quarterly to the Developmental Disability Services Board.⁸ DRA talked with facility staff and administrators to discern not only the extent and type of restraints used in the facility but also the efforts to provide programming to reduce restraint incidents. DRA also consulted with an expert in facility practices, including reducing the use of restraint in facilities.⁹

DRA has concluded that the restraint practices at Booneville HDC are both contrary to currently recognized best practices regarding restraints and puts residents and staff at risk of physical and emotional harm. Furthermore, DRA has concluded that the restraint practices at Booneville HDC will not be eliminated without serious scrutiny and comprehensive changes within the facility.¹⁰

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Regulations and Policies Governing Use of Restraints

Intermediate care facilities for individuals with developmental disabilities, such as Booneville HDC, must meet certain federal standards in order to receive Medicaid reimbursement.¹¹ The Centers for Medicare and Medicaid Services regulations govern these types of facilities and provide requirements for compliance in order for those facilities to maintain their Medicaid funding. Within those regulations are specific criteria regarding the use of restraints at institutions such as Booneville HDC.

Facilities must “[e]nsure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.”¹² Physical restraints are only allowed as part of an individualized program intended to result in less restrictive means of managing a specific behavior, on an emergency basis if required to protect the resident or others from injury, or as prescribed by a physician to be used during specific medical or surgical procedures, or while a medical condition exists.¹³

Written policies and procedures regarding the management of any inappropriate behaviors must be developed so that these types of interventions are done on a continuum; the least restrictive means of managing a behavior must be attempted first before resorting to more intrusive methods.¹⁴ These policies and procedures are intended to ensure that a resident’s human and civil rights are protected and that restraints are not used “for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program.”¹⁵

The Division of Developmental Disabilities Services (DDS) within the Arkansas Department of Human Services (DHS) has developed a policy related to behavior management that the HDCs are required to follow.¹⁶ This policy notes that the agency’s philosophy is to use positive approaches to behavior management before utilizing more restrictive approaches.¹⁷ It also recognizes that “[e]fforts at positive programming prove to be successful with the majority of maladaptive behaviors.”¹⁸

“The goal is to eliminate the use of seclusion and restraint in behavioral health, as the use of seclusion and restraint creates potential physical and psychological dangers to the persons subject to the interventions, to the staff members who administer them, or those who witness the practice.”¹⁹

Restrictive methods, including restraints, which are used as part of an individual’s behavior program, should be limited to those “individuals who repetitively engage in *dangerously aggressive* behavior and for whom other interventions have not been effective.”²⁰

Restraints must also include documentation that other, less restrictive methods of addressing behavioral issues have previously been tried and failed. The program should be carefully reviewed and interventions are proving ineffective.²¹

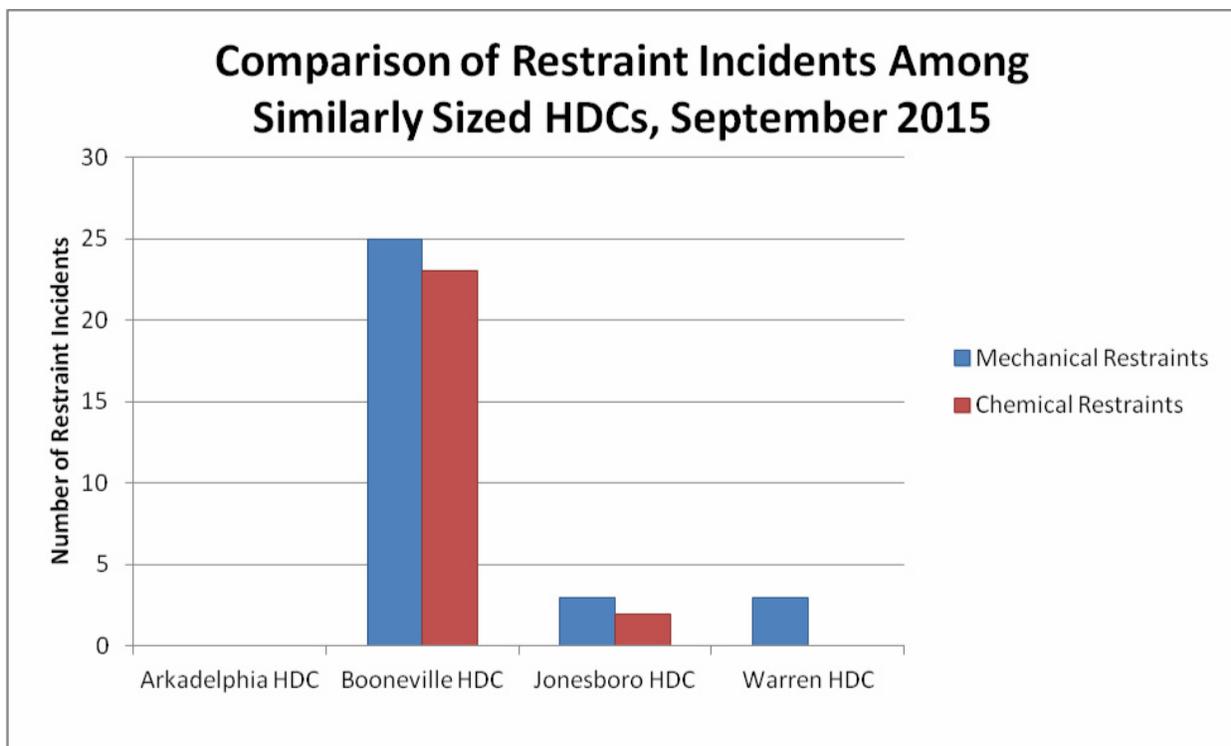
monitored by professionals and revised if the interventions are proving ineffective.²¹ Regardless of how they are labeled, restraints, both personal and mechanical, should only be used to prevent personal injury or serious property damage.

Booneville HDC also has an internal policy and procedure for managing behaviors that recognizes that it is not effective to control behavior by coercion²² and that personal or mechanical restraints for behaviors should only be used in emergency situations.²³ Emergency restraints are only to be used when a behavior is *severely aggressive* or *destructive* and never for punishment or convenience.²⁴ Emergency mechanical restraints are only to be used when all other means of behavior control have been exhausted and when the individual is “so aggressive that restraint is necessary to prevent *imminent* physical harm to themselves, others, or property.”²⁵

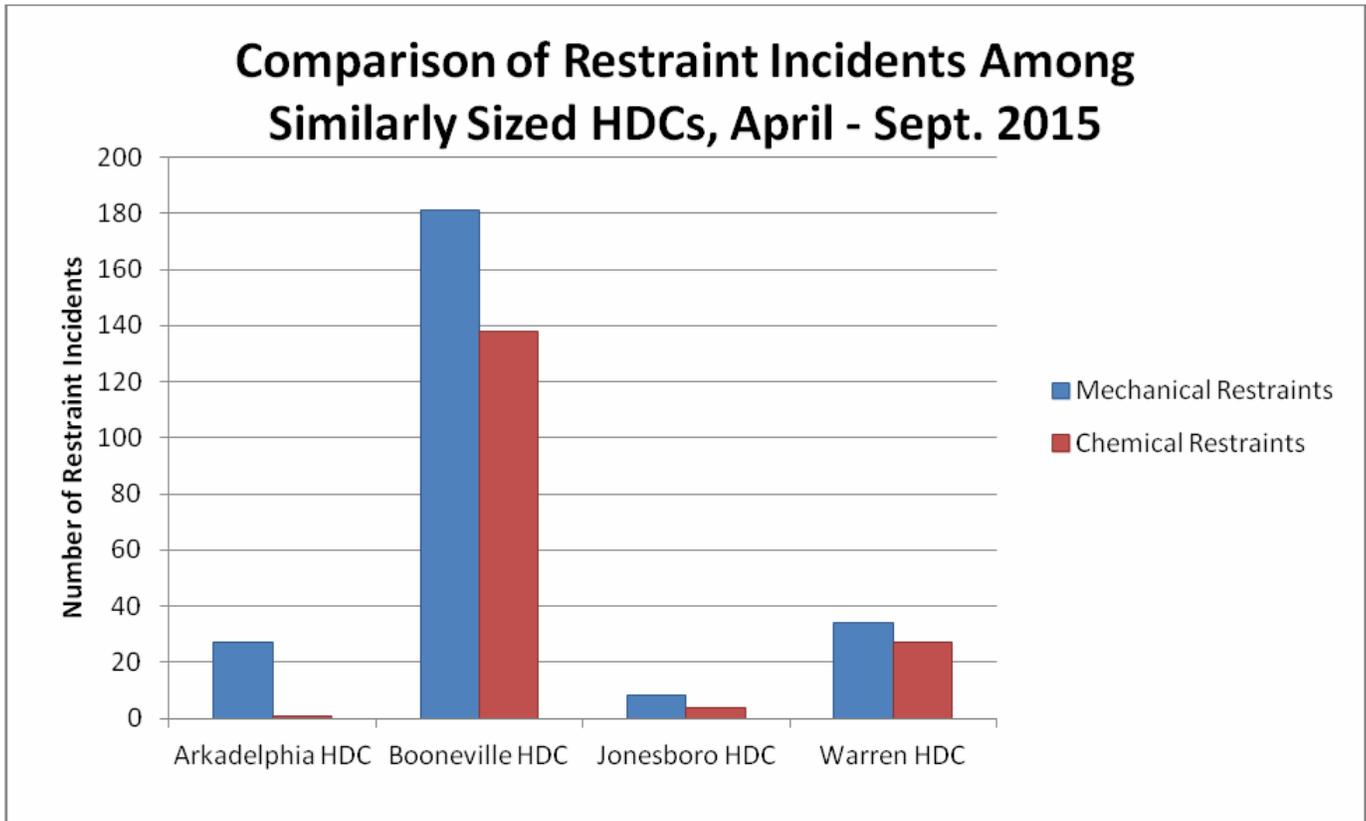
Booneville HDC Has A Significantly Higher Number of Restraints than Similar HDCs

As part of examining the use of restraint at Booneville HDC, DRA compared the frequency of restraint use at that facility with the three other similarly sized HDCs, which are in Arkadelphia, Jonesboro, and Warren.²⁶ Booneville HDC continues to have more restraints, in relation to population, than the other similar HDCs.²⁷

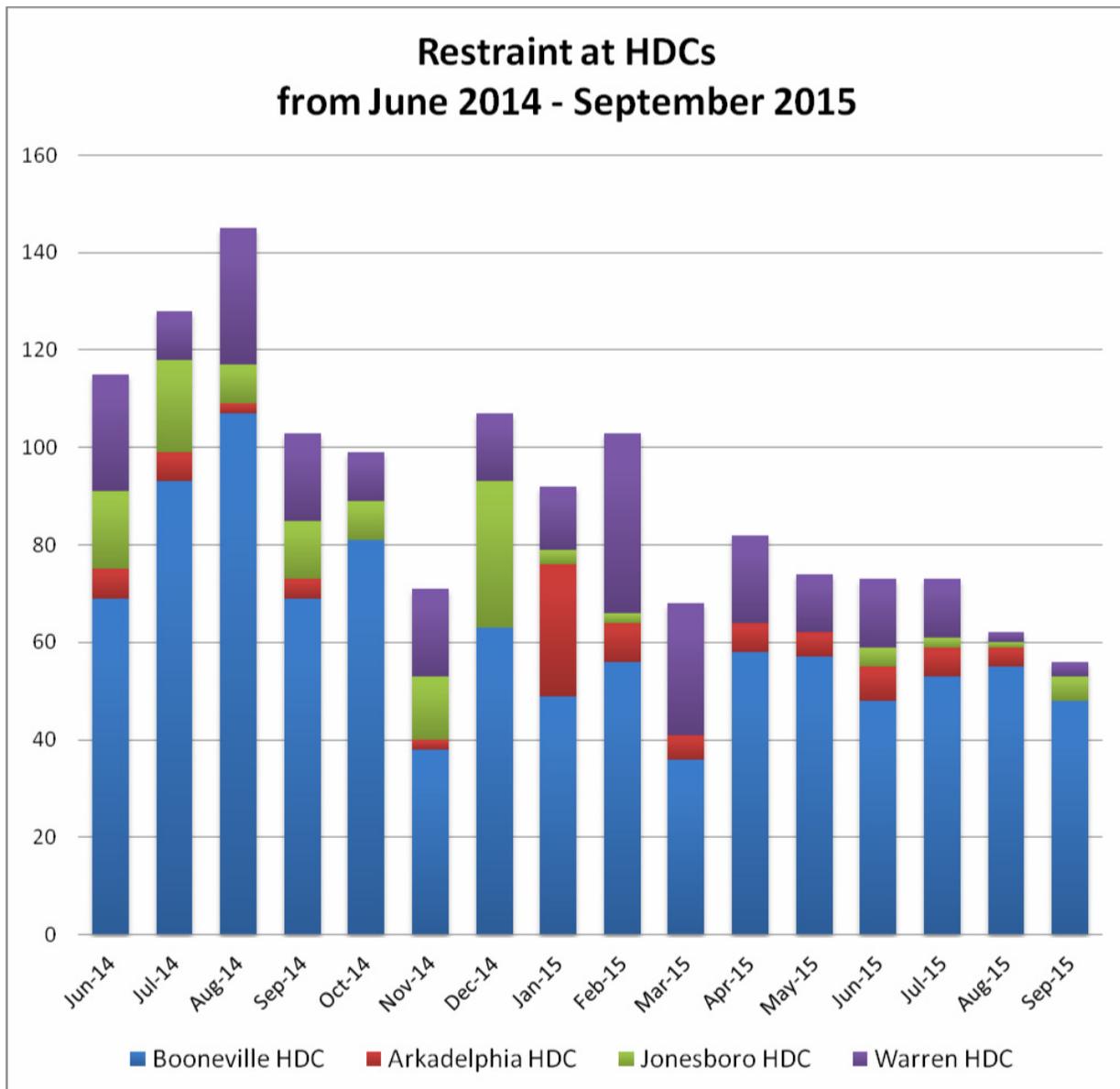
In September 2015, Booneville HDC’s population was 122 residents, and it reported 25 mechanical restraints and 23 chemical restraints.²⁸ By comparison, Arkadelphia HDC’s population was 117 residents, and it reported no restraints. For further comparison, Jonesboro HDC’s population was 104 residents, and it reported 3 mechanical restraints and 2 chemical restraints. Warren HDC’s population was 92 residents, and it reported only 3 mechanical restraints and 0 chemical restraints.



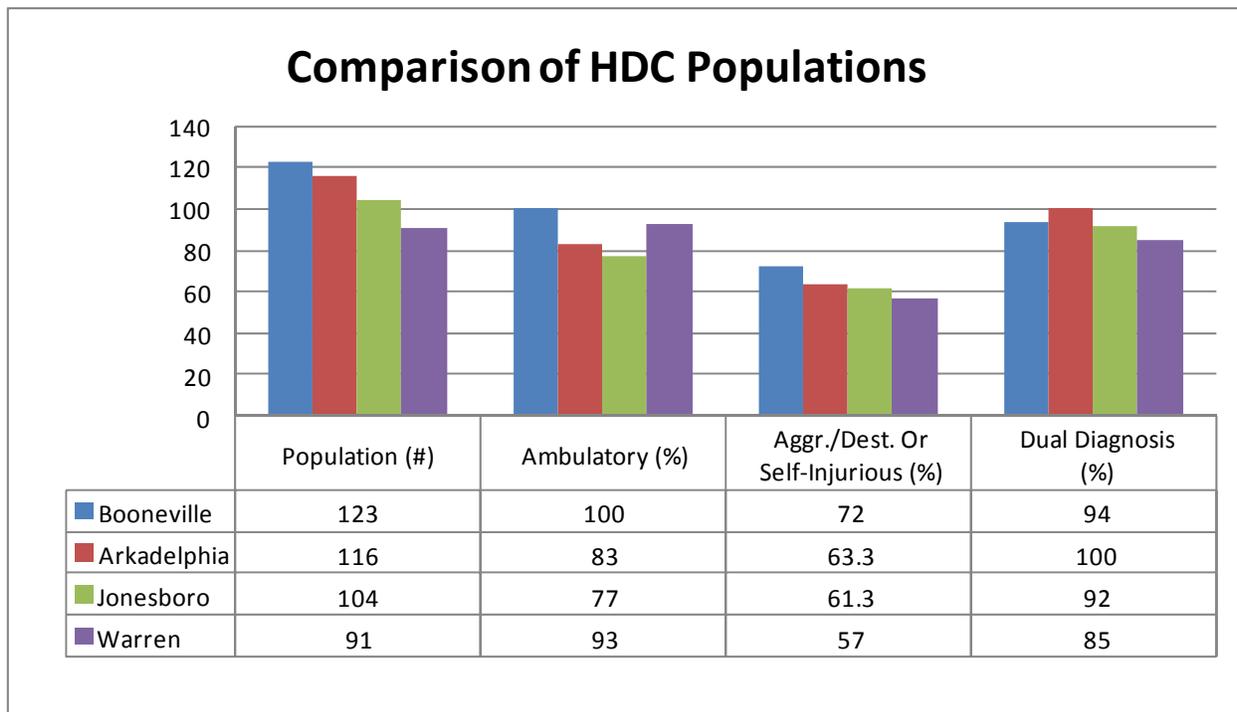
The September 2015 results are not an anomaly. Restraint numbers reported for the preceding six months yielded the same result—Booneville HDC has consistently higher incidents of restraint when compared with other HDCs of similar size and character. From April through September 2015, Booneville HDC reported a total of 181 mechanical restraints and 138 chemical restraints. Arkadelphia HDC reported 27 mechanical restraints and 1 chemical restraint. Jonesboro HDC reported 8 mechanical restraints and 4 chemical restraints during that same reporting period. Warren reported 34 mechanical restraints and 27 chemical restraints during that same period.



Each month over a sixteen month period from June 2014 to September 2015, Booneville HDC consistently utilized more restraints than any of the other comparable HDCs *combined*.²⁹ While Booneville HDC has reduced the number of restraints occurring at the facility, the average number of restraints is still approximately twenty-five times higher than the average number of restraints at other HDCs.



As shown in the graph below, the remaining HDCs (Arkadelphia, Jonesboro, and Warren) are comparable in not just the raw number of residents but also in the percentage of residents who (1) have a dual diagnosis, (2) have been identified as exhibiting aggressive/destructive or self-injurious behavior, and (3) are ambulatory.³⁰



These particular characteristics were chosen for comparison because the Department of Human Services has explained the higher number of restraints at Booneville HDC, stating: “the number of times restraints are used at Booneville tends to trend higher than other HDCs, and we believe that relates to the fact that Booneville specializes in serving only intellectually or developmentally disabled, ambulatory individuals with severe behavioral challenges [. . .]”³¹ Therefore, DRA compared the number of HDC residents reported to have a dual diagnosis, which means a resident has both a developmental disability and a mental health diagnosis. The HDCs have nearly even numbers of individuals with dual diagnoses.³² In fact, according to recent reports from the HDCs, Arkadelphia HDC has the highest number of residents with a dual diagnosis among the HDCs compared.

DRA also compared the percentage of residents who have been identified as having “aggressive/destructive” or “self-injurious” behaviors according to reports from the HDCs. While Booneville HDC has a marginally higher percentage of residents who exhibit these identified behaviors, the other HDCs have a significant number of residents with these same types of behaviors.³³ This difference in the number of residents who have been identified as having “aggressive/destructive” or “self-injurious” behaviors does not justify the uncommonly high number of restraints at Booneville HDC.

Finally, DRA compared the percentage of ambulatory residents and found some difference.³⁴ All of the residents at Booneville HDC are ambulatory, which is necessary due to the inaccessibility of its campus for persons with mobility impairments. However, there are significant numbers of ambulatory residents at the other HDCs as well. The small disparity in the number of ambulatory residents at Booneville HDC does not explain the large discrepancy between the number of restraints at Booneville and at the other HDCs.

Restraint is Inherently Dangerous

Concern over the high number of restraints used at Booneville HDC comes from the inherent dangers associated with these types of interventions. Published studies and articles have discussed the risks associated with restraints, which can include physical injuries, significant trauma, and death.³⁵ Due to these recognized risks, numerous institutions across the country providing services to individuals with mental health or developmental disabilities, or training professionals to do so, have worked to eliminate the use of restraints. They have done so due to the potential for serious physical and psychological harm, both to the individual restrained and to the staff implementing the restraint.³⁶ Many organizations across the country have also agreed that restraint should be a last resort and used only in instances where serious injury is imminent.³⁷

Booneville HDC's Restraint Incident Debriefing Form acknowledges the danger of restraints to both staff and residents, noting that the "use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used." However, restraints routinely occur at Booneville HDC where, based on documentation of the incident, the risk of serious injury was not imminent. As a result of restraint use, residents at Booneville HDC have sustained injuries ranging from scrapes and scratches to large, multiple bruises and even broken bones.

*"The use of physical restraints can cause harm including strangulation, loss of muscle tone, decreased bone density (with greater susceptibility for fractures), pressure ulcers, decreased mobility, depression, agitation, loss of dignity, incontinence, constipation, and in some cases, resident death."*³⁸

Types of Restraints at Booneville HDC

At Booneville HDC, there are five approved restraint procedures, techniques, and devices—

1. personal restraints;
2. chemical interventions;
3. protective helmets;
4. papoose board; and
5. wrist restraints.³⁹

Based on our review of documents, the methods used most often are personal restraints, chemical interventions, and the papoose board. Personal restraints are procedures that limit movement by physically holding the hand or limb.⁴⁰ However, this procedure can range from a hand on the shoulder to forcing a resident to the ground and forcibly holding him or her there, sometimes with a knee in the resident’s back and a forearm across the back of the resident’s neck.

Chemical interventions/restraints involve the administration of a drug to restrict a resident’s movement or to sedate him or her. The most commonly used chemical interventions at Booneville HDC are Ativan and Haldol.⁴¹ Ativan is labeled as a medication to treat epileptic seizures and to sedate patients before surgery.⁴² Side effects can include central nervous system depression, respiratory depression, dizziness, confusion, depression, sobbing, and delirium.⁴³ Meanwhile, Haldol is used to treat schizophrenia and Tourette’s Disorder.⁴⁴ Its known adverse reactions or side effects include tachycardia, hypotension and hypertension, impaired liver function, anorexia, constipation, diarrhea, hypersalivation, nausea, vomiting, visual disturbances, insomnia, anxiety, agitation, depression, and “potentially irreversible, involuntary, dyskinetic movements.”⁴⁵ Chemical restraints are often given in conjunction with a mechanical or personal restraint.⁴⁶

The final method of restraint reviewed for this report is the papoose board. This “mechanical restraint” is a device that limits movement and range of motion.⁴⁷ It resembles a padded board with straps to hold a resident tightly to the board in a way that prohibits movement and completely controls a resident’s body. Frequently, the term “graduated guidance” is used to describe the method of moving a resident to the papoose board and represents how a staff member must struggle with and force a resident, who does not want to be restrained, onto this restrictive device. The papoose board is used for longer periods of time than personal restraint. At least one resident has been strapped to the papoose board for six hours in a single day, while only being released for mandatory breaks every 55 minutes.



Papoose Board currently used at Booneville HDC

Use of Restraints at Booneville HDC

Booneville HDC's policies require that less restrictive measures be used before resorting to restraints. According to the documentation reviewed by DRA, restraints often occur when a lack of meaningful intervention by staff has led to an escalation in the resident's behavior.

Staff often use restraint when Booneville HDC's policy would dictate a less restrictive intervention. Staff document less restrictive interventions most often in the form of redirection, direction, or sanctions. Redirection routinely takes the form of simply telling an agitated or upset resident to "stop," "calm down," or "go back to work." Residents will also be told that they risk having a privilege taken away. None of these strategies actually address the needs of the resident, or the motives of the behavior, and frequently accomplish nothing but escalation of the resident's behavior.

This is concerning because some of the residents at Booneville HDC are in restraints for extended lengths of time.⁴⁸ In the fourteen month period between January 2014 and February 2015, the cumulative time residents were personally or mechanically restrained ranged anywhere from one minute to nearly four full days.⁴⁹ The average cumulative time a resident at Booneville HDC spent in either personal or mechanical restraints was over five hours for that period of time.⁵⁰

A few examples from the period of January 2014 through February 2015 illustrate the lengths that residents have been restrained on a papoose board:

- Resident 1 was restrained every month and restrained a total of 59 hours and 17 minutes during this time frame.
- Resident 2, who also was restrained every month, was restrained a total of 64 hours and 51 minutes during this time frame.
- Resident 3 was restrained in all but one month and was restrained a total of 94 hours and 57 minutes during this time frame.
- Resident 4, who was also restrained in all but one month, was restrained a total of 84 hours and 22 minutes.

The restraint documentation also does not provide enough information regarding *why* a behavior escalated, or what occurred before the incident that led to the behavior. Instead, the focus is limited to the resident's actions that led to the restraint, without regard to the reason for the behavior. Resident behaviors and actions are consistently examined in a vacuum, divorced from any context or meaning, and viewed only as compliant or non-compliant. Staff involved in restraint incidents rarely document the reason for a behavior, or suggest any changes to the individual's program as a way to address the problematic behavior. This is true even in instances when a resident's behavior tends to occur in identifiable patterns, frequently taking place at the same time of day, with the same residents, or in the same location.

*“Seclusion and restraints have no therapeutic value, cause human suffering, and frequently result in severe emotional and physical harm, and even death.”*⁵¹

Example: Resident was upset that another resident was telling her what to do. Staff intervened in the situation, but they stated it was too late. Staff report that Resident was then engaging in self-injurious behavior and spitting at staff. Staff also report that *Resident asked the staff to restrain her on the papoose board and give her a chemical restraint.* Resident was strapped to the papoose board for 40 minutes. There was no insight regarding program changes or the motivation for the behavior other than agitation by a co-resident.

Identifying the function that a particular behavior serves is one of the most important aspects of modifying a challenging behavior. This important step is relatively nonexistent at Booneville HDC. Instead, the same residents are subjected to repeated restraints with no attempts at providing them with needed therapy and tools for them to use to adapt their behavior.

Most human behavior has meaning. Professional staff, with training to identify that meaning, should be carefully reviewing all restraint documentation and events leading up to a restraint in order to better provide direct care staff with an understanding of what the resident is seeking to communicate with a behavior. For this to occur, staff involved in the restraint must consistently document what happened prior to the escalation of the behavior so that a true understanding of the behavior can take place.

A related issue that is apparent from review of restraint documentation at Booneville HDC is that staff routinely relies on rule enforcement instead of resident engagement. When a resident does not “comply” with a rule, a restraint often follows. This is typically due to a resident’s resistance to being directed to do some action that he or she does not want to do at the time. Instead of engaging with that resident to determine why there is resistance, or to find alternate avenues that allow for resident expression, staff often will try to force the resident to comply, which only escalates the situation.

Example: Resident did not want to go to his room for shift change. When staff attempted “graduated guidance” to get him to his room, he started threatening and swinging at staff. One of the staff members fell on Resident, *breaking his collar bone.* Resident was then strapped to the papoose board for 50 minutes. There was no indication that any staff member questioned Resident to see why he did not want to go to his room. When staff asked Resident for his input to prevent future restraints, he replied that he would like to go to either the Arkansas State Hospital or jail as opposed to staying at Booneville HDC.

In fact, non-compliance is frequently used throughout the restraint documentation as justification for why a restraint was used. Non-compliance places the blame and consequences for a behavior on the resident. The focus on non-compliance reflects an outdated philosophy that exists at Booneville HDC and likely contributes to the frequency of restraints. In many similar institutional settings across the country, non-adherence has replaced non-compliance as a best practice. Non-adherence acknowledges a resident’s choice in treatment and gives information to the provider that the resident needs to be better engaged in the program.

Example: Resident was asked to take a shower due to having a bowel movement in his pants during a seizure. Resident became upset with staff after they told him several times to take a shower. He swung at a staff member and was promptly strapped to the papoose board for thirty minutes until he agreed to shower. There were no recommendations to help prevent a similar event from occurring again.

Another concern is the frequency with which Booneville HDC staff routinely restrain residents based on behaviors that they classify as “attention-seeking.” Restraint documentation revealed that events leading up to a resident being restrained were often due to a resident attempting to gain the attention of staff members. When those attempts were unsuccessful, due to staff either ignoring the resident or trying to redirect their actions, the resident’s behavior would escalate, and restraint would result. The use of restraints in these instances is inappropriate and would be unnecessary if staff were provided with training on best practices to enable them to better understand a resident’s need for attention and how to appropriately respond to that need.

The record below is an excerpt from a Restraint Incident Debriefing Form.⁵² This restraint began with the resident having displayed self-injurious behavior, leading to a personal restraint. She calmed herself enough to have breakfast and take her medications, at which point a nurse announced that she was still going to administer a chemical restraint in the form of a shot. This, according to staff, escalated the resident’s behavior. Upon reflection, the staff member filling out the debriefing form recommended that the nurses be more discrete when administering chemical restraints. There is no documentation that explains why staff thought a chemical restraint was necessary after the resident was already calmed.

3. Interaction with Staff: (Was the interaction with this person and the client performed in such a way as to deescalate the situation or a factor in escalating the behavior? Was this person someone whom the client likes or not? Could a different staff person have interacted with the client and avoided the emergency restraint?) Please Describe:

We calmed [redacted] to the point of taking her meds and have breakfast. The nurse [redacted] stated, I'm still gonna give her that shot and [redacted] threw her water and [redacted] went to bite herself and fight staff.

6. Recommendations: (Are there any recommendations from the Client, the Intervention Team and/or the Restraint Leader that could help prevent a similar event from occurring again?) Please List:

Have staff not say things like the Nurse said in front of clients. Need to be discreet.

Another important issue is that documentation of a restraint requires the use of multiple forms, which, though intended to capture the entire event, often miss critical pieces required to truly understand what happened. As noted earlier, staff members tend to document the resident’s behavior after it has already escalated. There is little attention given to events leading up to the escalated behavior, to effective interventions prior to the use of restraint, or to an analysis of how the restraint could have been avoided.

Furthermore, the Restraint Incident Debriefing Form is often completed or reviewed at a later date, which does not aid in identifying patterns or avenues for reducing the use of restraints for that resident. DRA's review of the restraint documentation revealed that many residents experience restraints repeatedly during the same day, week, or month. Without a prompt review and thorough discussion of the restraint, the resident is subjected to repeated instances of this dangerous, dehumanizing, and coercive intervention that could have been avoided had that review taken place.

Example: According to a *Behavior Report*, Resident was restrained for threatening to kill staff and himself, and he relentlessly continued this behavior while restrained on a papoose board for one hour and thirty-five minutes; however, a *Chemical Intervention Checklist* for the same incident states that Resident "was calm until he heard staff talking about how he needed a shot." Yet another document, the *Restraint Incident Debriefing Form*, does not mention the interaction with staff that escalated Resident's behavior.

Residents in institutional settings rely on staff members for all of their basic needs. The majority of their days are spent on the same campus, in the same rooms, with the same individuals. As such, it is simply human nature to seek out attention in a variety of ways. Instead of ignoring or punishing that behavior, staff should be working with residents to better engage them in their treatment programs and in the world outside of the Booneville HDC campus.

Example: Resident made a homemade badge and was pretending that he worked at Booneville HDC. He began telling clients what to do. When staff tried to redirect him, he punched a staff member. He was strapped to a papoose board for 35 minutes. When asked to reflect on programmatic issues that could be made to prevent the restraint, the staff member writes, "no changes could of [sic] helped this behavior." No effort was made to transfer Resident's imagined role as a staff member to a purposeful activity before resorting to restraints.

Lack of Meaningful Follow-up

Though restraints are routinely used at Booneville HDC, there is a lack of meaningful follow-up by the facility in order to identify alternative avenues of behavior management. While other institutions across the country seek to eliminate the use of restraints, Booneville HDC has shown marginal movement towards that goal. Review of documentation revealed that the same residents are repeatedly restrained without consideration of ways to avoid the use of restraint.

Booneville HDC uses a "Restraint Incident Debriefing Form" that is to be completed by staff following an emergency restraint.⁵³ When an incident occurs, a restraint incident leader is to conduct a debriefing session with other staff involved, as well as the resident, to pinpoint the behavior that led to restraint, environmental factors involved, antecedents to the behavior, staff actions that could have kept the situation from escalating, the resident's reaction, and any programmatic changes or resident options that could have prevented the restraint.⁵⁴

While staff members appear to complete the debriefing forms with regularity following a restraint, the documentation frequently does not provide the information that the questions intend to target. Many times the answer is simply “none.” The area designated for resident input often does not include information from the resident to better understand the resident’s point of view. There is little documentation of ways the restraint could have been avoided.

In addition, staff routinely place the blame for the use of restraints on the resident’s “bad behavior,” without regard to how the staff’s own actions may have contributed to the escalation. Though there is an area that allows staff to put recommendations as to how to avoid restraints in the future, staff members rarely have suggestions. A review of the debriefing forms reveals that direct care staff members involved in administering the restraints do not see any other options and just accept restraint activity as a necessity. This reflects a culture at Booneville HDC where overuse of restraint is the norm.

Lack of Meaningful Oversight

Booneville HDC does have a Human Rights Committee (Committee) that is intended to protect the rights of Booneville HDC residents. The Committee, which is required and established by both the Division of Developmental Disabilities Services and Booneville HDC policies, is tasked with a number of functions, one of which is to review the restraint activity at Booneville HDC.⁵⁵ However, the Committee rarely, if ever, questions the use of restraint. The meeting minutes reflect that the Committee routinely approves the use of restraints, even for those residents who are repeatedly restrained during a review period, with no discussion documented as to ways to prevent those restraints in the future. Though the same residents often are included in the review month after month, there appears to be no effort by the Committee to question the course of action or to reduce the use of restraints. Instead, there appears to be acceptance, facility-wide and by the Committee, that the use of restraints is the status quo.

Conclusion

According to the data collected and maintained by Booneville HDC and the State, residents at Booneville live in an environment in which restraint is used excessively, far more frequently than at the Arkadelphia, Jonesboro, or Warren HDCs. Booneville HDC fails to ensure that staff utilize effective tools to de-escalate situations, leading to the use of restraints when other interventions, if implemented sooner, could eliminate the need for restraint. The Department of Human Services and its Division of Developmental Disabilities Services has failed to provide the oversight and training to ensure that residents at Booneville HDC are not subjected to unnecessary and excessive restraints. Residents and staff have already been injured due to the current restraint practice at Booneville HDC.⁵⁶

All HDC residents are entitled to live in an environment in which restraints are used as a last resort after other interventions have failed. The residents at Booneville HDC have a right to be treated with dignity and respect, to not be subjected to unnecessary and harmful restraint, and to receive active treatment based on evidence-based best practices. DRA urges the State to take immediate action to address the culture at Booneville HDC and to instruct Booneville HDC to stop this inherently dangerous practice. The individuals with disabilities residing at Booneville HDC deserve better.

Recommendations

DRA recommends that the State take the following steps to ensure that residents at Booneville HDC are protected from excessive and unnecessary restraint:

1. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should retain an independent expert with expertise in working with facilities to develop and implement current evidence-based best practices at Booneville HDC to significantly reduce and/or eliminate the use of restraint at the facility.
2. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should provide and require participation of Booneville HDC's senior administrative, clinical, and direct care staff in comprehensive training on person-centered and trauma-informed, recovery-oriented, evidence-based services and supports.
3. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC's senior administrative and clinical staff should be required to develop a strategic plan to transform this institution to one that adopts current, best practice philosophy, vision, and values. This plan should be updated monthly and reviewed quarterly by the state office or an external entity.
4. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC should ensure that all facility staff immediately receive extensive training and are intensively monitored to ensure that evidence-based best practices are used to avoid escalation of behaviors and the use of restraint. DRA recently learned that Booneville HDC has begun training some facility staff on Nonviolent Crisis Intervention Training. Nevertheless, the number of restraints at Booneville HDC are still much higher than at the other HDCs.
5. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that the use of restraint at Booneville HDC is regularly monitored, including careful evaluation and scrutiny of the reasons staff utilized restraint, alternatives to restraint, and follow-up actions in response to restraint. This includes requiring that clinical and senior administrative staff be more involved in the day-to-day activities of residents to ensure that individualized treatment or behavior plans are effective and that adequate active treatment is provided.
6. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that residents of Booneville HDC have access to active treatment, including the provision of mental health and other treatment that supports residents in addressing their challenging behaviors in ways that do not include coercion or punishment.
7. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ban the use of the papoose board as a form of restraint at Booneville HDC and other HDCs.

Endnotes

- ¹ About DDS, <http://humanservices.arkansas.gov/ddds/Pages/AboutDDDS.aspx> (last visited Dec. 3, 2015).
- ² Developmental disability is defined as “‘an impairment of general intellectual functioning or adaptive behavior’ that is a ‘substantial handicap to the person’s ability to function without appropriate support services, including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training.’ It is caused by mental retardation or a closely related condition; cerebral palsy; epilepsy; autism; or dyslexia (difficulty learning to read and spell) resulting from cerebral palsy, epilepsy, or autism. [. . .] The definition also includes ‘a functionally retarded person who may not exhibit an intellectual deficit on standard psychological tests, but who, because of other handicaps, functions as a retarded person.’” Gloria Gordon, *DDS Children’s Guide*, (2005) (citing Arkansas Code. § 20-48-101 (2015) and Arkansas Act 729 of 1993), http://humanservices.arkansas.gov/ddds/ddds_docs/ddds_childrens_guide.pdf.
- ³ *Booneville Human Development Center Description of Services and Programs*, Meeting of the Hosp. and Medicaid Study Subcomm. of the Ark. Legis. Council, 89th General Assemb. Exhibit D-2 (Jan. 8, 2014), <http://www.arkleg.state.ar.us/assembly/2013/Meeting%20Attachments/080/112304/Exh%20%20D-2-Booneville%20HDC.pdf>.
- ⁴ Ark. Building Authority, *Human Development Centers Condition Assessment Report for Arkansas Department of Human Services*, Developmental Disabilities Services, (2015). According to this Assessment, Booneville HDC requires an additional \$79,755,937 in order to modernize the campus, which does not take into account the cost of ADA compliance, code compliance, demolition of unused buildings, or remediating hazardous material present. Therefore, it is reasonable to assume that a detailed assessment including these factors would likely be much higher.
- ⁵ Disability Rights Arkansas, Inc., *A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center*, (2015), <http://disabilityrightsar.org/wp-content/uploads/2015/11/BHDC-Final-Report-January-2015.pdf>.
- ⁶ In *Olmstead*, the United States Supreme Court held that needlessly segregating individuals with disabilities is a form of discrimination that is prohibited by the Americans with Disabilities Act. The Court decision “that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. . . . Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” *Olmstead*, 527 U.S. at 600-01 (citations omitted). *Olmstead* directed states to serve individuals in the most integrated setting appropriate to meet their needs. See e.g., United States Department of Justice Civil Rights Division, *Olmstead: Community Integration for Everyone*, <http://www.ada.gov/olmstead/index.htm> (last visited Dec. 28, 2015); United States Department of Health & Human Services Office of Civil Rights, *Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, <http://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html> (last visited Dec. 28, 2015); Judge David L. Bazelon Center for Mental Health Law, *The Olmstead Decision*, <http://www.bazelon.org/Where-We-Stand/Community-Integration/Olmstead-Implementing-the-Integration-Mandate/The-Olmstead-Decision-.aspx> (last visited Dec. 28, 2015).
- ⁷ See United Cerebral Palsy, *The Case for Inclusion 2015*, (2015), http://cfi.ucp.org/wp-content/uploads/2015/07/UCP_2015_CaseforInclusion_FINAL.pdf. According to this report, Arkansas is one of the worst states in the country for providing alternatives to institutional care, ranking number 49, and has consistently ranked as one of the worst states since United Cerebral Palsy’s first report in 2007.
- ⁸ The Developmental Disabilities Services Board (DDS Board) is charged with the oversight of the services provided to Arkansans with developmental disabilities. Arkansas Act 348 of 1985 reorganized DHS, placing the Division of Developmental Disabilities Services (DDS) under its authority, and designated control and administration of the HDCs under the management and direction of the DDS Board. The mission of DDS and the DDS Board includes a commitment to the positive management of challenging behaviors, and protection of the constitutional rights of individuals with disabilities, and their rights to personal dignity, respect and freedom from harm.

⁹ DRA consulted with Dr. Kevin Ann Huckshorn, who is a licensed and certified mental health nurse and substance abuse clinician with 36 years of experience working in a variety of public and private behavioral health organizations. She has published on topics including violence, treatment adherence, trauma-informed care, and workforce development and has co-authored a book with William Anthony, PhD, titled “Principled Leadership in Mental Health Systems and Programs” (2008). Dr. Huckshorn is the President and CEO of Kevin Huckshorn & Associates, Inc., a small behavioral health consulting business. She is the former Director of the Division of Substance Abuse and Mental Health in Delaware. She led the development of the evidence-based best practice titled “The Six Core Strategies” and was involved in the successful implementation of a United States Department of Justice settlement agreement in Delaware.

¹⁰ DRA wants to emphasize that these conclusions are not meant as any type of reflection on the community of Booneville and its residents who work at Booneville HDC. DRA’s conclusions are intended to address the shortcomings in the State’s provision of active treatment and safe care to HDC residents and to encourage the State to take the necessary steps to change the culture at the facility by reducing and eliminating the use of restraint.

¹¹ Centers for Medicare & Medicaid Services, *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)*, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/ICFMR_Background.pdf.

¹² 42 C.F.R. § 483.420 (a)(6) (2015).

¹³ 42 C.F.R. § 483.450 (d) (2015).

¹⁴ 42 C.F.R. § 483.450 (b)(iii) (2015).

¹⁵ 42 C.F.R. § 483.450 (b)(3) (2015).

¹⁶ Arkansas Department of Human Services Division of Developmental Disabilities Services, Policy No. 3011-D *Behavior Management*, (2003), available at <https://ardhs.sharepointsite.net/DDS%20Policies/Forms/By%20Policy%20Type.aspx>.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ 2012 CARF Behavioral Health Standards Manual: Section 2.F. Nonviolent Practices/Nonviolent Crisis Intervention Training Program, (May 2012), https://www.crisisprevention.com/CPI/media/Media/Resources/Knowledge-Base/Carf_alignment.pdf.

²⁰ *See supra* note 16.

²¹ *Id.*

²² Booneville Human Development Center, Policy No. I-D-2, *Use and Documentation of Procedures to Manage Behavior*.

²³ Booneville Human Development Center, Policy No. I-D-4, *Documentation of and Response to Maladaptive Behaviors*.

²⁴ *Id.* at (2)(a) (emphasis added).

²⁵ *Id.* at (2)(f) (emphasis added).

²⁶ Conway HDC has over four hundred residents (more residents than the other HDCs combined) and serves a population that includes children and medically fragile residents; therefore, it will not be considered for comparison to Booneville HDC, which only has 121 residents. Conway Human Development Center, <http://humanservices>.

arkansas.gov/ddds/Pages/ConwayHDC.aspx (last visited Dec. 3, 2015) (explaining that Conway HDC has residents ranging from ages 7 to 74).

²⁷ *Human Development Center Monthly Statistical Reports* provided quarterly to the DDS Board.

²⁸ *Human Development Center Monthly Statistical Reports*, September 2015.

²⁹ *Human Development Center Monthly Statistical Reports*, June 2014-September 2015.

³⁰ Based upon data contained within the *Human Development Center Monthly Statistical Reports*, July 2015-September 2015.

³¹ Max Brantley, *State Responds to Report on Conditions at Booneville Human Development Center*, The Arkansas Times Blog (Jan. 5, 2015, 11:40AM), <http://www.arktimes.com/ArkansasBlog/archives/2015/01/05/state-responds-to-report-on-conditions-at-booneville-human-development-center>.

³² The average number of residents with dual diagnoses within Arkadelphia, Jonesboro, and Warren HDCs is 92.75%, whereas 94% of Booneville HDC's residents have a dual diagnosis.

³³ The average number of residents who have exhibited self-injurious or aggressive/destructive behaviors among Arkadelphia, Jonesboro, and Warren HDCs is 63.4%. Booneville HDC has 72% of its residents who exhibit those behaviors, which is only slightly higher than the average of the other HDCs.

³⁴ The average number of ambulatory residents within Arkadelphia, Jonesboro, and Warren HDCs is 88.25%. At Booneville HDC, 100% of the residents are ambulatory.

³⁵ See, e.g., Stephan Haimowitz, Jenifer Urff, & Kevin Ann Huckshorn, *Restraint and Seclusion—A Risk Management Guide*, (2006), <http://www.nasmhpd.org/sites/default/files/R-S%20RISK%20MGMT%2010-10-06%282%29.pdf>; United States General Accounting Office, Report to Congressional Requesters, *Mental Health: Improper Restraint or Seclusion Use Places People at Risk*, (1999), <http://www.gao.gov/archive/1999/he99176.pdf>; United States General Accounting Office, Testimony Before the Committee on Finance, U.S. Senate, *Mental Health: Extent of Risk From Improper Restraint or Seclusion Is Unknown*, (1999), <http://www.gao.gov/archive/2000/he00026t.pdf>; Stacey A. Tovino, "Psychiatric Restraint and Seclusion: Resisting Legislative Solution," 47 Santa Clara L. Rev. 511 (2007); Equip for Equality, *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint*, (2011), <http://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf>.

³⁶ See *supra* note 35.

³⁷ See *supra* note 35.

³⁸ Centers for Medicare & Medicaid Services, *Freedom from Unnecessary Physical Restraints: Two Decades of National Progress in Nursing Home Care*, (Dec. 3, 2015), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09-11.pdf>.

³⁹ Booneville Human Development Center, Policy No. I-D-4(6), *Documentation of and Response to Maladaptive Behaviors*.

⁴⁰ *Id.*

⁴¹ Booneville HDC Chemical Intervention Checklists from 2014 and 2015.

⁴² *Ativan (lorazepam) Injection*, (2015), http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/018140s0281bl.pdf.

⁴³ *Id.*

⁴⁴ *Haldol (haloperidol) Injection*, (2009), http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/015923s0841-bl.pdf.

⁴⁵ *Id.*

⁴⁶ Booneville HDC Resident Behavior Reports and Chemical Intervention Checklists from 2014-2015.

⁴⁷ Booneville Human Development Center, Policy No. I-D-4(6), *Documentation of and Response to Maladaptive Behaviors*.

⁴⁸ *See* Appendix 1, which incorporates data from Human Rights Committee Reports furnished by Booneville HDC for the time period of January 2014 to February 2015. DRA compiled the aggregate times residents were in either personal or mechanical restraints per month.

⁴⁹ *Id.*

⁵⁰ This average includes residents who were not restrained at all during their time at Booneville HDC. If averaging the length of time in restraints for only persons who were actually restrained at Booneville HDC, the number of hours would be over 9 ½ hours. *See* Appendix 1.

⁵¹ Mental Health America, *Position Statement 24: Seclusion and Restraints*, <http://www.mentalhealthamerica.net/positions/seclusion-restraints> (March 2011) (last visited December 2, 2015).

⁵² *See* Appendix 2.

⁵³ *See* Appendix 2, which is an actual set of forms from a restraint incident, redacted to protect the privacy of the residents involved.

⁵⁴ Booneville Human Development Center, Policy No. I-D-4(2)(f)(v), *Documentation of and Response to Maladaptive Behaviors*.

⁵⁵ Booneville Human Development Center, Policy No. I-C-2(1)(a-d), *Human Rights Committee*.

⁵⁶ Resident injuries were previously described herein. Several employees at Booneville HDC who were placed on Worker's compensation leave from 2013-2015 were reportedly injured by "client behavior." Booneville Human Development Center, Worker's Compensation Report.

Appendix 1

MONTHLY NUMBER OF MINUTES RESTRAINED PER RESIDENT

	02/15	01/15	12/14	11/14	10/14	09/14	08/14	07/14	06/14	05/14	04/14	03/14	02/14	01/14	Total	Total (hours)
Resident		1.00										55.00		45.00	101	1h 41m
Resident	26.00						75.00		149.00						250.00	4h 10m
Resident								45.00	1.50						46.50	46.5m
Resident			1.00	18.00		323.00									342.00	5h 42m
Resident			25.50						2.00	3.00					30.50	30.5m
Resident							5.00						1.00		6.00	6m
Resident	170.00				123.00				45.00						338.00	5h 38m
Resident												3.00			3.00	3m
Resident					42.00	1.00				55.00				30.00	128.00	2h 8m
Resident		3.00	3.00	25.00				26.50	1.00					34.00	92.50	1h 32.5m
Resident		3.00	45.00	110.50	1.00		8.50	37.00	1.50	74.50		44.00	55.00	30.00	410.00	6h 50m
Resident									15.00				1.50		16.50	16.5m
Resident														30.00	30.00	30m
Resident		37.00	30.00		30.00	15.00					13.00			3.00	128.00	2h 8m
Resident					1.00										1.00	1m
Resident				2.00	145.00	43.00				56.00	5.00	60.00	1.00		312.00	5h 12m
Resident						18.00							5.00		23.00	23m
Resident									2.00						2.00	2m
Resident	35.50	72.00	34.00	104.00	11.00	51.50	112.00	87.00	341.00	110.00	11.00	126.00	87.50	140.00	1322.50	22h 2.5m
Resident							2.00		1.50				20.00		23.50	23.5m
Resident	15.00	13.00	7.00	30.00	43.00		6.00	5.50						22.00	141.50	2h 21.5m
Resident		57.00	150.00	88.00	12.00	109.00	95.00	15.00	96.00	94.00	184.00		7.00		907.00	15h 7m
Resident	23.00	80.00	129.00	111.50	335.00	190.00	214.00	694.00	45.00	215.00	80.00			93.00	2209.50	36h 49.5m
Resident			139.00		50.00			45.00	35.00	35.00	45.00			45.00	394.00	6h 34m
Resident								2.00					2.00		4.00	4m
Resident	53.00	2.00				13.00		90.00			4.00		1.00	11.00	174.00	2h 54m
Resident					15.00	13.00									28.00	28m
Resident											2.00				2.00	2m
Resident	2.00	41.00		85.00	15.00		60.00	52.00	26.00		122.00	8.00	15.00	37.50	463.50	7h 43.5m
Resident		2.00			8.00										10.00	10m
Resident							55.00	45.00	293.00	130.00	40.00	55.00	45.00	55.00	718.00	11h 58m
Resident	210.00	71.00	123.50	11.00	38.00	131.00	431.00	554.00	514.50	270.00	99.00	572.00	3.00	529.50	3557.50	59h 17.5m
Resident					27.00		38.00			30.00		45.00			140.00	2h 20m
Resident								3.00							3.00	3m
Resident		150.00							31.00					4.00	185.00	3h 5m
Resident	26.00				30.00							2.00	2.00		60.00	1h
Resident		57.00	75.00	70.00	85.00		60.00	10.00		83.00		18.00			458.00	7h 38m
Resident		85.00	58.00		365.00	190.00	34.00	3.00	173.00			57.00			965.00	16h 5m
Resident			1.00				22.00								23.00	23m
Resident			56.00									165.00		1.00	222.00	3h 42m
Resident	17.00	4.00						59.00							80.00	1h 20m
Resident								2.00							2.00	2m
Resident			158.00	3.00	119.00	213.00	483.00	231.00	79.50	55.00	628.00	71.00	1.50	365.00	2407.00	40h 7m
Resident								3.00							3.00	3m
Resident	288.00	90.00	425.00		560.00	585.00	240.00	325.00	145.00	832.00	676.00	291.50	161.50	1078.00	5697.00	94h 57m
Resident	54.00	88.00	35.00	73.00	129.00	43.00	61.00	97.00	38.00		15.00	120.00	264.00	165.00	1182.00	19h 42m
Resident	3.00	71.00			30.00	1.00	34.00			80.00					219.00	3h 39m
Resident							36.00								36.00	36m
Resident		4.00	11.00	4.00	1.00	58.00			5.00			3.50		10.50	97.00	1h 37m
Resident	203.00	298.50	475.00	298.00	450.50	169.00	235.00	270.00	319.00	83.00	353.50	424.00	208.00	105.00	3891.50	64h 51.5m
Resident			1.00												1.00	1m
Resident	50.00	86.00		55.00	165.00	314.00	161.00		82.00				65.00		978.00	16h 18m
Resident								52.00	45.00					165.00	262.00	4h 22m
Resident	75.00	120.50	229.50	2.50	166.00		888.00	730.50	213.00	700.50	128.00	857.50	115.00	836.50	5062.50	84h 22.5m
Resident	160.00	4.00	136.00	31.00	73.00	58.00	168.00	165.00	125.00	251.00	80.00	316.00	199.00	241.00	2007.00	33h 27m
Resident			17.00			29.00		46.00							92.00	1h 32m
Resident	3.00		90.00	85.00		20.50	10.00							4.00	212.50	3h 32.5m
Resident												23.00			23.00	23m
Resident				29.00		35.00				20.00	103.00	194.00	55.00		436.00	7h 16m
Resident								4.00							4.00	4m
Resident	1.00				90.00										91.00	1h 31m
Resident		1.00													1.00	1m
Resident	1.00			30.00						24.00	35.00				90.00	1h 30m
Resident			63.00	35.00	64.00	100.00	20.00		20.00	278.00	175.00	115.00	154.00		1024.00	17h 4m
Resident			5.00												5.00	5m
Resident	35.00		1.50												36.50	36.5m
Resident	45.00		223.00		164.00	130.00	195.00	77.00	132.00	49.00	125.00	55.00	157.00	150.00	1502.00	25h 2m
Resident										40.00		170.00			210.00	3h 30m
Resident			4.00		1.00	65.00	8.00		19.00	33.00	124.50		61.00		315.50	5h 15.5m
Resident									27.00			45.00			72.00	1h 12m

Appendix 2

Booneville Human Development Center RESTRAINT INCIDENT DEBRIEFING FORM To be completed and turned in with the Restraint Log

The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program), when a very real risk of personal injury or severe property damage is imminent.

INCIDENT:

On [redacted] as placed in mechanical restraint
Date Client name

as documented on the attached Restraint Log. The reason that the use of restraint was necessary because (describe the behavior):

[redacted] was calm enough to get her meds and then have breakfast, the nurse stated she was still gonna give her the shot and [redacted] threw her water and went to bite herself and fight staff.

I. The Restraint Incident Leader was [redacted]

Signature

II. The other members of the Intervention Team were:

Signature

Signature

Signature

Signature

Signature

III. Event Analysis:

The following may be contributing factors to this restraint incident:

1. Physical Environment: (Where did the incident occur, were there anything in the physical environment that may have been a factor in the incident?) Please Explain:

In med pass area

2. Interaction with Peers: (Was another person's interaction with the client a factor in the client requiring restraint?) Please Describe:

Boonville Human Development Center
RESTRAINT INCIDENT DEBRIEFING FORM
To be completed and turned in with the Restraint Log

3. Interaction with Staff: (Was the interaction with this person and the client performed in such a way as to deescalate the situation or a factor in escalating the behavior? Was this person someone whom the client likes or not? Could a different staff person have interacted with the client and avoided the emergency restraint?) Please Describe:

We calmed [redacted] to the point of taking her meds and have breakfast. The nurse [redacted] stated I'm still gonna give her that shot and [redacted] threw her water and

4. Programmatic Issues: (Were there any programming issues involved in the incident, such as requests to perform assigned tasks such a laundry, room maintenance, going to class, bathing, etc. involved in the incident? Could any programmatic changes be made to prevent similar incidents such as doing laundry at a different time or day, etc?) Please Describe:

None

Went to bite herself and fight staff.

5. Client Input: (Actively seek information from the client as to what could be done to prevent such an incident in the future. Did the client feel that staff overreacted in the incident or did they feel the restraint was justified?) Please Describe:

She ignored staff

6. Recommendations: (Are there any recommendations from the Client, the Intervention Team and/or the Restraint Leader that could help prevent a similar event from occurring again?)

Please List:

Have staff not say things like the Nurse said in front of clients. Needs to be discreet.

IV. Reviewed by:

[redacted signature]
Signature, Title

Date

[redacted date]

RECEIVED

[redacted] 2015

RECORDS ROOM
BHDC AR 72927

BEHAVIOR REPORT DOCUMENTING EMERGENCY RESTRAINT
 NAME: [REDACTED] LOCATION: Hillside House V DATE: [REDACTED] TIME: 0715
 Client has a BTP? Yes No (Information only) Device inspected before use? Initials of inspector: [REDACTED] Device used: Pa pose Board

Describe the event: the staff response; and efforts made by staff to avoid the use of restraint. Mechanical Restraint must be authorized/reauthorized every 15 minutes.

Initial Behavior Leading to Restraint: [REDACTED] had displayed SIB behavior where she was held in personal restraints (See BR) - [REDACTED] was calm enough to pop her meds
 Physical Intervention/Redirection Attempts (be specific): there was no time at this point.
 Choices offered: there was no time at this point.
 Graduated Guidance used? Yes No
 Behavior threatening injury to people or damage to property (be specific): Continuous SIB behavior, trying to bite herself and fighting staff.

Staff Signature and Title: [REDACTED] Date: [REDACTED] Time: 0715
 Authorization for Restraint Signature and Title: [REDACTED] Date: [REDACTED] Time: 0715

MEDICAL DEPARTMENT USE ONLY--NURSES NOTATION (Name, Title, Date, and Time of each observation):
0715 Client on board circulation good to all extremities -
Chemical intervention of Ativan 2mg given in per orders

BEHAVIOR REPORT DOCUMENTING EMERGENCY RESTRAINT

Time started	15 minute checks	Staff Name, Title	Indicate behavior requiring restraint; whether the dangerous behavior is continuing; and what resulted in release	Authorization every 15 / minutes
0715		[REDACTED]	attempted sro and fighting staff chemical given @ 0720	[REDACTED]
	0723	Released	Calm	
	55 minutes Release		Was released for fluids, meals, toileting Ongoing Behavior:	Reauthorized every 15 minutes
	55 minutes Release		Released for fluids, meals, toileting Ongoing Behavior:	Reauthorized every 15 minutes
			<div style="border: 1px solid black; width: 100px; height: 100px; background-color: black; margin: 0 auto;"></div>	RECEIVED 2015 RECORDS ROOM BHDC AR 72927
	55 minutes Release		Released for fluids, meals, toileting Ongoing Behavior:	Reauthorized every 15 minutes

JUSTIFICATION AND AUTHORIZATION FOR MECHANICAL RESTRAINTS

Client response to intervention and alternate behavioral choices: He got up put his shoes on and went and ate breakfast

Staff debriefing form completed by Restraint Incident Leader? yes Restraint Incident Leader Signature, Title, and Date: [REDACTED]

Suggested measures to avoid restraint use: Staff needs to be more discreet.

Injury noted upon release NO YES Suggested measures to insure safety: Staff needs to be more discreet.

Regulations: Restraint is only used as an emergency procedure to prevent or minimize imminent danger of injury to people or serious damage to property. All efforts must be made to deescalate the incident prior to the use of restraint. The person in restraint must be under constant staff observation, documented every 15 minutes. The person must be released when calm. The person must be released from restraint every 55 minutes for fluids, toileting, meals, or exercise. Restraint use must be authorized; continued use must be reauthorized after 15 minutes.

DisabilityRights



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