GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT ON DISABILITY SERVICES

DDS TRANSMITTAL# 19-23

TO: **All Developmental Disabilities Administration (DDA) Residential and Day Services Providers**

FROM: **Crystal Thomas, Program Manager, State Office of Policy, Planning and Innovation**

DATE: **January 15, 2020**

RE: **DDS Guidelines for the Safe Use of Physical Restraints During Crisis Support**

The Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), is sharing this transmittal, effective January 15, 2020 to clarify guidelines for the approved use of physical restraint in behavior support plans (BSPs, see BSP Policy and Procedures) and to raise immediate awareness about the risks of using physical restraint during acute behavioral crises. This transmittal also includes a best practices recommendation in paragraph 6 that a nursing assessment be completed within one hour after a physical restraint has been used and again within the next 24 hours to address the dangers of physical injury and asphyxiation, and that the person be observed during the 24-hour period for changes in health condition.

1. When Physical Restraint May Be Used For Crisis Support

a) Physical restraint is for protection when there is a credible and immediate threat of harm to self or others. It is not intended to change behavior where there is no protective need.
b) Physical restraint is recommended only when all less restrictive methods of intervening have been tried and the person still presents a danger to self or others.
c) Physical restraint should only be used when the danger presented by the target behavior outweighs the risks of physical interventions.
d) Physical restraints must be removed as soon as the person is no longer an immediate threat to self or others.

2. CPI and MANDT Are The Only Two Crisis Support Programs Approved By DDS

DDS recognizes two specialized instruction programs for crisis support with people who have disabilities: Nonviolent Crisis Prevention and Intervention (CPI) and the Mandt System (MANDT). The CPI and MANDT emphasize communication strategies, relational skills, and nonverbal communication strategies for use during acute behavioral episodes. Training in CPI and MANDT also includes competency-based training in the use of physical restraint interventions when nonphysical interventions are insufficient.

a) Staff training in CPI and MANDT must be conducted by a certified trainer.
b) In accordance with the Revised Training Procedure for DDA Providers (2019-DDA-PROC01), initial training and recertification in CPI or MANDT must be conducted by a

live trainer, rather than online training or digital training, and staff must be recertified in CPI or MANDT at least annually.

c) The initial training in CPI or MANDT and recertification training must require the staff person to demonstrate 100% competency to implement physical restraints in order to be certified.
d) Staff who are expected to implement physical restraint interventions as part of the BSP must maintain 100% competency in between annual recertifications. Since physical restraint interventions are part of the BSP, training records uploaded with the BSP for Restrictive Controls Review Committee (RCRC, see 2013-DDA-PR014) review must document that staff have demonstrated 100% competency in the appropriate use of physical restraints each time she or he is trained on the person's BSP.
e) For residential and day services providers who employ staff that are responsible for implementing physical restraint interventions included in the BSP, the provider must maintain documentation showing current certification for each staff person in accordance with the Revised Training Procedure for DDA Providers.

3. The Use of Physical Restraint For Crisis Support Poses Substantial Medical/Physical And Psychological/Emotional Risks

Being restrained is highly stressful, both physically and emotionally. People can go from a state of no distress to death in minutes.

Physical/medical risks associated with the use of physical restraints include, but are not limited to:

a) Bruising;
b) Joint injuries;
c) Broken bones;
d) Loss of blood circulation to the limbs;
e) Falls; and
f) Asphyxiation (*i.e.* suffocation), of which there are three types:

i. Positional asphyxiation occurs when the person is restrained in a position in (including face-up) which he cannot breathe properly. Death can result from lack of oxygen to the brain and disturbance in the rhythm of the heart.
ii. Compression Asphyxiation occurs when someone sitting or lying across a person's back, stomach, arms or legs restricts the person's breathing by preventing the diaphragm and abdomen from moving.
iii. Restraint Asphyxiation occurs when an increase in stress hormones triggered during physical restraint increases the person's risk of abnormally rapid heart rate and difficulty processing oxygen (hyperventilation). Sudden death can occur up to 24 hours after restraint.

Psychological/emotional risks associated with the use of physical restraint include, but are not limited to:

a) Psychological trauma to the person;
b) Psychological trauma to the staff;
c) Damage to the relationship between the person and the staff; and
d) Escalation of the acute crisis episode.

4. Guidelines For The Approved Use Of Physical Restraint

These guidelines are effective January 15, 2020, for any new BSPs as well as for BSPs that are pending review by RCRC. For BSPs that are currently approved by RCRC, these guidelines should be implemented on a rolling basis throughout the year as current BSPs expire.

The use of physical restraint is subject to RCRC, which will review the following:

a) A person's BSP must include detailed descriptions of each physical restraint that will be used for safety in a crisis situation.
b) The BSP must describe when the use of physical restraint will be initiated, the maximum duration of time that each physical restraint hold can be applied, and specific instructions about when the restraint should be discontinued.
c) The use of physical restraint is limited to a cumulative total of 30 minutes within a two-hour time period. After 30 cumulative minutes within two hours, the provider shall call 911 or take the person to the emergency room for assessment. The longer the application of physical restraint continues, the more dangerous the crisis situation becomes.
d) Providers must obtain annual documentation of medical clearance from a primary care physician verifying that the person does not have any medical conditions that would make the use of restraint dangerous. Even if medical clearance is provided, RCRC may still reject the use of physical restraint in the BSP if it is not clinically justified.

5. Seven Physical Restraint Practices Expressly Prohibited By DDS

The following physical restraint practices are expressly prohibited by DDS's Human Rights Policy (2013-DDA-H&W-POL007):

a) The use of any physical restraint that is not time limited. Restraints must be removed as soon as the person is no longer an immediate danger to self or others.
b) Prone (face down) restraint.
c) Any restraint that restricts breathing.
d) Physical restraint that places the person on the floor or any other surface with staff on top of the person.
e) Physical restraint that relies on pain for control.

f) Physical restraint that relies on a take-down technique in which the person is not supported and allows for a free fall to the floor or another surface.
g) Any physical restraint that is not part of CPI or MANDT.

6. **NEW: A Nursing Assessment Should Be Completed After Physical Restraint Use**

The CPI and MANDT manuals, and best practices guidelines, require that a nursing assessment be completed immediately after the use of physical restraint (within one hour) in order to evaluate the person for stable vital signs, respiratory distress, and physical injury and again within the next 24 hours to assess for symptoms of restraint asphyxiation that can develop later. Because health consequences of physical restraint can appear up to 24 hours following the use of restraint, any person who has been restrained should be observed for 24 hours for changes in health condition that require medical attention including, but not limited to, difficulty breathing, unconsciousness, diarrhea, bleeding, disorientation, seizure, vomiting, broken bones, skin discoloration, joint damage, unequal pupil size, signs of pain, etc.

If you have questions about this transmittal, please contact Tiffani Johnson, JD, Rights and Advocacy Specialist, at (202) 730-1802, (202) 271-3710, or tiffani.johnson@dc.gov, or Dr. Yolanda Van Horn, DDS Clinical Psychologist, at (202) 527-5541 or yolanda.vanhorn@dc.gov.