SAFETYNETWORKS
Information for Elder Adults-at-Risk and Adults-at-Risk Agencies
AAR Information Memo # 8, October 2008

IN THIS ISSUE

Guidance for County Elder Adults/Adults-at-Risk (EA/AAR) Agencies and Adult Protective Services (APS) in responding to reports of unreasonable confinement or restraint of elder adults/adults at risk who reside in unregulated community settings.

SUMMARY

Adults who have paid caregivers, live in regulated, licensed or certified settings, or are placed in a community setting have the right to be free of unreasonable confinement and restraint under Wisconsin Statutes (Wis. Stats.) 51.61(1)(i) and by Wisconsin Administrative Code section HFS 94.10. These laws and regulations do not apply to individuals who live in unregulated community settings (e.g., family homes or apartments) and receive services and supports from uncompensated caregivers (typically family members). However, individuals are protected under Wisconsin's elder abuse/adults-at-risk statutes, protective services laws, and federal Medicaid Home and Community-based waiver requirements.

Well-meaning families and caregivers often believe the use of a restraint is necessary to keep the elder adult/adult at risk safe from harm. The family or caregiver may not believe that the use of the restraint or confinement is inappropriate or unreasonable. The use of the restraint by the family or caregiver may not be malicious. However, unreasonable confinement or restraint **IS** abuse as defined under elder adults/adults-at-risk law.

This document is intended to assist county staff in understanding their role in identifying inappropriate restrictive measures and in developing response strategies for elder adults/adult at risk who are subject to inappropriate restrictive measures, predominately in unregulated settings.

LAWS PROTECTING ADULTS PLACED IN A COMMUNITY SETTING OR LIVING IN REGULATED, LICENSED OR CERTIFIED SETTINGS

Wis. Stats. 51.61(1)(i) and Wisconsin Administrative Code HFS 94.10 regulate the use of restraint in licensed or certified settings and community placements. While these regulations do not govern use of restraint in unregulated settings, they provide guidance to assist county staff in identifying unreasonable confinement and restraint in these settings.

- **Wis. Stats. 51.61(1)(i)** states in part that each *patient*[1] who is receiving paid services shall "have a right to be free from physical restraint and isolation except for emergency situations…." The law goes on to define that isolation or restraint can only be used when a less restrictive measure is ineffective.

- **HFS 94.10** gives people who meet the definition of *patient* (above) the right to be free of restraints. HFS 94.10 requires the Department and/or the county to approve the non-emergency use of restrictive measures in community settings. Approval must be sought on a case-by-case basis.

[1] Patient is defined in Wis. Stats. 51.61. See Appendix A for a full definition of patient and other key terms.

PROTECTING INDIVIDUALS LIVING IN UNREGULATED COMMUNITY SETTINGS FROM UNREASONABLE CONFINEMENT OR RESTRAINT

If a person does not meet the definition of *patient* (above), the state and counties do not have the legal authority to approve/disapprove the use of restraints. However, other statutes and federal regulations protect Wisconsin citizens from unreasonable confinement and restraint. Wisconsin elder-adults/adults-at-risk laws provide protections from the use of unreasonable confinement or restraint by including restraint under the definition of abuse.

> **Wis. Stats. 46.90 (1) (a) 5.** includes unreasonable confinement or restraint under the definition of abuse. "Unreasonable confinement or restraint" includes the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his or her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the Department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint.

Individuals, who receive protective services whether on a voluntary or involuntary basis, have a right to be free from physical restraint and isolation except for emergency situations.[2]

Also, the federal Centers for Medicare and Medicaid Services requires states to assure the ***health and safety*** of all people funded by Medicaid home and community-based waivers including CIP 1A/B Waiver, BI Waiver, CLTS, COP-W/CIP II Waiver, COR Waiver and the Family Care Waivers. County waiver agency and managed care organization (MCO) staff that operate these programs are responsible for developing service plans and creating systems that assure waiver participant safety and welfare, including freedom from abuse, neglect and mistreatment.

GUIDING PRINCIPLE

The Department's mission is to promote the *least restrictive* principle in all services and settings. As this mission relates to unreasonable confinement and restraint, the goal is to keep all individuals free from restraint regardless of where they live, who cares for them, or if services are compensated or unpaid.

Restrictive measures must be avoided to the extent possible, used as the method of last resort, and employed only when necessary to ensure the immediate safety of the person and/or others. Before restrictive measures can be used, caregivers of an individual who engages in dangerous/challenging behavior must try positive, proactive supports to influence the behavior. As with paid providers, the use of restrictive measures by unpaid care givers should be preceded by thoughtful attempts to use less restrictive, less intrusive, alternative strategies to determine if such methods can adequately support the individual's positive behaviors, thereby avoiding the need for restrictive measures. Only after it has been determined that less restrictive support strategies are ineffective may restrictive measures be considered. Use of confinement or restraint by uncompensated, natural supports such as family may constitute abuse and must be avoided to the extent possible.
Therefore, the use of restraint should be dealt with uniformly under the elder adults/adults-at-risk statutes, under federal waiver regulations, in licensed facilities or under the Department/county approval process.

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[2] Under Wis. Stats. 55.23 (Patient's Rights)

Reports of Unreasonable Confinement and Restraint of Elder Adults/Adults at Risk

When county waiver, MCO support and service coordinators, care managers or provider agency staff encounter situations where they believe a restraint is being used in an unreasonable manner, he/she should consider taking any or all of the actions below:

- Take appropriate action to manage emergency situations.
- Work with county waiver agency or MCO staff with experience in behavior supports and confinement and restraint who may review the client's service plan and suggest modifications or alternatives to the use of unreasonable confinement or restraint.
- Contact the county's Client Rights Specialist (CRS) responsible for client's rights issues under 51.61, Wis. Stats. The CRS can be helpful in determining if the use of restraint appears to be unreasonable, determining if there has been a violation of client's rights, and identifying potential methods of decreasing the challenging behaviors that motivated the use of the restraint.
- Call law enforcement whenever he/she judges the restraint to be a violation of criminal law.
- Report restraint use in a licensed, regulated facility to the Division of Quality Assurance (DQA) Regional Office Licensing staff if the use was not approved.
- Contact state elder adults/adults-at-risk staff for assistance if the restraint is being used on a "patient," as defined above, but not in a facility regulated by the Department.[3]
- Contact the county EA/AAR agency.

Guidance for EA/AAR Staff in Assessing Unreasonable Confinement and Restraint of Elder Adults/Adults at Risk

If a report is made to the county EA/AAR agency, these staff will use their experience and discretion in deciding what response is in the best interest of the elder adult/adult at risk.[4] What response is best for the individual is determined by consulting a wide variety of professionals and most importantly, discussing the situation with the elder adult/adult at risk.

[3] Department staff will assist in determining the best resources and contact information (i.e. state waiver or client's rights staff) to assist in this situation. A list of state contacts is provided at the end of this SafetyNetWorks (Page 7).

[4] DMHSAS Memo Series 2007-12: The adult-at-risk agency is responsible for making its own determination about whether to respond to a particular report or indication of abuse. The elder adult-at-risk system requires a response or investigation or referral of every report of abuse, neglect or exploitation. However, the extent of the response is at the discretion of the local agency.

Together with waiver, MCO staff and others, the EA/AAR worker needs to examine the following questions:

1. Is the elder adult/adult at risk being confined or restrained? What is the elder adult/adult at risk doing that may require the use of restraint? Why do the caregivers believe that the restraint is needed? Is the restraint measure appropriate for the situation? Are there alternatives to the device being used? Is the device being used in a safe manner? How does the elder adult/adult at risk respond to the restraint?

2. Does EA/AAR staff believe that the restraint was being used unreasonably in a manner that harms or endangers the individual to the extent that the district attorney or law enforcement should be involved?

3. Is there a need for guardianship or protective placement/services? Is intervention needed? What is the best option for the elder adult/adult at risk? What other interventions are available? Could the caregiver transition down to less restraint or no restraint? What less restrictive interventions have been tried and demonstrated to be ineffective for managing the person's behavior? (*The answers to these questions are based on the beliefs and findings of the EA/AAR staff*.)

4. Is the caregiver capable of changing to another intervention? Is it workable given the situation, setting, and caregiver abilities?

See Appendix B for examples to assist in answering these questions.

To answer these questions, EA/AAR staff should seek the assistance of people who have experience and training with restrictive measures and behavioral intervention whenever possible. Also, the criteria used to evaluate restrictive measures in licensed facilities or when there are paid caregivers should be used to determine appropriateness of the restraint. **ALL** the following criteria must apply for a restraint to be considered appropriate:

1. The individual's behavior presents an immediate danger to self or other persons (e.g. hitting, biting, and scratching self or others). *Note: Actions such as property destruction, yelling at others, verbal threats with no ability to act are not behaviors that constitute an immediate danger to self or others.*

2. The restrictive measure proposed is the least restrictive approach available to achieve an acceptable level of safety for the individual and others. This applies to each measure proposed and to the interactive effects, if any, of all such measures.

3. Less restrictive interventions have been tried and were not effective.

4. The measure is adequately supported by training provided to all individuals involved in the use or monitoring of the measure.

5. Supervision, monitoring and back-up arrangements are adequate to ensure effective responses to unanticipated reactions to the measure that might arise.

6. During the use of the measure, the health, safety, welfare, dignity and other rights of the individual are adequately ensured.

7. There is a plan for reducing and even eliminating the need for using the measure in a reasonable length of time.

8. The restrictive measure is used only for the duration necessary to ensure the individual's safety or that of others (i.e., use of the restrictive measure stops as soon as the individual appears to be calm and not a danger to self or others).

9. The restrictive measure is not used in lieu of adequate support for the convenience of the caregiver or in lieu of appropriate and adequate treatment.

COUNTY EA/AAR RESPONSE TO UNREASONABLE CONFINEMENT OR RESTRAINT

Tools available to county EA/AAR staff include, but are not limited to:

- Take appropriate emergency action, including emergency protective placement, if it is determined to be in the adult at risk's best interests and is the least restrictive appropriate intervention.
- Recommend or refer to helpful services and supports or related resources that could provide useful information about alternatives to restraint use.
- Transport an elder adult/adult at risk to a doctor for a medical examination.
- Bring a petition for guardianship and/or protective services or placement, or review of an existing guardianship.
- Contact law enforcement if there is reason to believe that substantial physical harm, irreparable injury or death may occur to the adult at risk.
- Refer case to law enforcement officials for further investigation or to the district attorney if there is reason to believe a crime has been committed.
- Petition for a restraining order[5] on behalf of the elder adult/adult at risk.

County EA/AAR and waiver staff should also work with their county corporation counsel to develop guidelines and referral procedures for managing cases of abusive use of restraints by uncompensated natural support caregivers in an unregulated setting.

It should be stressed that these options apply to situations where the person is not a "patient" and therefore not protected by the rights under Wis. Stats. 51.61 and HFS 94. If the county EA/AAR staff encounters a situation involving a person who is being served by a provider under contract to a county or an MCO, other protocols are appropriate including but not limited to:

- Contacting the support and service coordinator/care manager from the county waiver agency or MCO to address the situation, or
- Contacting the Department's Division of Quality Assurance if the use occurs in a Department regulated facility. Staff from DQA can determine if the use of the measure has been or needs to be approved under the requirements of HFS 94.10 or Wis. Stats. 50.02 (2).

The role of EA/AAR staff is to respond to reports of abuse to elder adults/adults at risk. That abuse may include unreasonable confinement or restraint. It is not the responsibility of staff to assign fault or blame; although referral to law enforcement or the district attorney is a response available to the worker. The goal of the EA/AAR staff in all reports of abuse, including unreasonable restraint, is to work to alleviate hurt or harm to the elder adult/adult at risk.

[5] Wis. Stats. 55.043 (3)

EXAMPLES TO ASSIST IN DETERMINING ABUSIVE RESTRAINTS

There are a wide range of holds and devices that can be considered "restraints." Many restraints are used to protect us (i.e. the safety belts in your car), some are medically necessary (i.e. neck brace), some treat a medical condition (supportive chairs), others actually increase a person's level of independence (devices that assist in getting out of bed).

The following cases provide some issues to consider in determining if the restraint is abusive and examples of options available to alleviate the abuse. See Appendix B.

A woman in her 30's lives with her parents and displays significant self-injury, mostly in the form of biting her forearms and hitting her head on the floor. Since her discomfort and self-injury seems worse after meals, her father prevents the opportunity for self-injury by placing her in 5-point restraints for 30 minutes after dinner.

Some issues to consider:

- Has the family worked with their daughter's physician to determine whether medical issues are a factor in the self-injury? Is discomfort and pain after meals related to digestion? If so, is treatment available?
- Are there other factors that may be causing or exacerbating the behavior, such as noise and commotion during the meal? Does this occur at every meal? If not, are there patterns when it does occur? What is different about the meals when she exhibits the behaviors compared to the meals when she doesn't?
- Is she restrained after each meal in anticipation that she will try to harm herself? What was the basis for deciding that she should remain in restraints for 30 minutes after each meal? Does she appear to be calm prior to the end of the 30 minutes? The answers to these questions will help to determine if the restraints are being used arbitrarily and if the use of restraint appears to be abuse.

A 23 year old man with autism is living with his natural family and is restrained in his bed nightly using soft restraints tied around his waist. The parent's rationale for using this restraint is that their son is both visually and hearing impaired, and has a tendency to get up and wander at night. His parents feel that, since they know where he is, they can sleep better at night and this allows them to be better, more responsive caregivers.

Some issues to consider:

- What does the word "tendency" mean? How often does he get up at night and wander? Is this every night? Is he wandering or trying to go somewhere specific or to get something? What hazards exist in the home or nearby the home? Can any of the hazards be removed or risk mitigated (e.g., putting power tools in a locked cabinet or shed)
- If no one is awake at night to monitor their son what would happen if he hurt himself? Could the parent be viewed as neglecting him?
- Should/could the family be doing something differently? Is there a less restrictive way to reduce the risk – such as a door alarm that would alert the parents when the man leaves his room?

If you have questions about the information presented here or if you need help responding to a report of unreasonable confinement or restraint, here are some contacts that may be helpful.

Julie Shew
Adult Waiver Program State Restraint Lead
920-303-3026
Julie.Shew@wisconsin.gov

Vaughn Brandt
Client's Rights Office
608-266-9369
Vaughn.Brandt@wisconsin.gov

Kay Lund
State Elder Adults/Adults-at-Risk Program
608-261-5990
Kay.Lund@wisconsin.gov

Jane Raymond
State Elder Adults/Adults-at-Risk Program
608-266-2568
Jane.Raymond@wisconsin.gov

Dan Zimmerman
Bureau of Prevention, Treatment & Recovery
608-266-7072
Daniel.Zimmerman@wisconsin.gov

Caregiver Misconduct Statewide Complaint Helpline
1-800-642-6552

Division of Quality Assurance Regional Offices

Northeastern Regional Office 920-448-5240

Northern Regional Office 715-365-2800

Southeastern Regional Office..... 414-227-5000 or 414-227-2005

Southern Regional Office 608-266-7474

Western Regional Office..... 715-836-4752

APPENDIX A
Definitions Related to Unreasonable Confinement and Restraint

Restrictive Measures used in an Emergency Situations are limited to unanticipated occurrences of dangerous/challenging behavior that has not happened before, does not happen more than two times in a six month period and is not anticipated to occur again. The Department's *Guidelines and Requirements for Supporting People with Challenging/ Dangerous Behavior* define emergency as "an unanticipated situation in which a person engages in dangerous behavior that places the person or others at imminent, significant risk of physical injury, or exhibits signs known to be precursors of such behavior for that individual."

Examples of such behavior includes but is not limited to biting, striking or pushing another person, harming his or her own body by scratching, using objects to inflict injury or other such behaviors. Restrictive measures may be used only in emergency situations if **all** of the following conditions are present:

- An emergency exists (a person's behavior poses an immediate threat of harm to self or others);
- there is no approved behavior intervention plan for that person dealing with the planned use of restraint, isolation or protective equipment intended to address this behavior or there is an approved plan but it has been found to be ineffective; and
- the behavior in question has either not occurred previously, could not have been reasonably foreseen to occur based on past observations of the individual's behavior or the behavior was foreseen and the subject of a previously developed behavior intervention plan but the measures called for in the approved plan proved to be ineffective.

Informal caregiver or natural support person is someone who provides services or supports, above the level of room and board, to a person who requires assistance with the activities of daily living or who needs some level of supervision; whose support is neither paid for nor arranged by any governmental entity, directly or indirectly; and where the support occurs in a place that is not regulated by state or local government or their agents as a site for the provision of services or supports beyond room and board. [DHS Legal Counsel]

Isolation is the involuntary physical or social separation of an individual from others by the actions or direction of staff[6], contingent upon behavior. For example, the following are not isolation: 1) separation in order to prevent the spread of communicable disease, and 2) cool down periods in an unlocked room when the person's presence in the room is completely voluntary and there are no adverse consequences if the person refuses to go to the room. [Department Guidelines and Requirements for supporting People with Challenging/Dangerous Behavior]

Least Restrictive means support and services which will best meet the patient's needs and security and which least limit the patient's freedom of choice and mobility. [Wis. Admin. Code HFS 94.02 (27) Definitions]

Medical Restraint means an apparatus or procedure that restricts the free movement of a patient during a medical or surgical procedure or prior to or subsequent to such a procedure to prevent further harm to the patient or to aid in the patient's recovery, or to protect a patient during the time a medical condition exists [Wis. Admin. Code HFS 94.02 (29)].

[6] As it relates to this document, staff includes either paid or uncompensated caregivers.

Mechanical Support means an apparatus that is used to properly align a patient's body or to help a patient maintain his or her balance [Wis. Admin. Code HFS 94.02 (28)].

Patient is defined as any individual who is receiving services for mental illness, developmental disabilities, alcoholism or drug dependency, including any individual who is admitted to a facility in accordance with this chapter or ch. 48 or 55 or who is detained, committed or placed under this chapter or ch. 48, 55, 971, 975 or 980, or who is transferred to a facility under s. 51.35 (3) or 51.37 or who is receiving care or support for those conditions through the Department or a county department under s. 51.42 or 51.437 or in a private facility. "Patient" does not include persons committed under ch. 975 who are transferred to or residing in any state prison listed under s. 302.01. In private hospitals and in public general hospitals, "patient" includes any individual who is admitted for the primary purpose of treatment of mental illness, developmental disability, alcoholism or drug abuse but does not include an individual who receives treatment in a hospital emergency room nor an individual who receives treatment on an outpatient basis at those hospitals, unless the individual is otherwise covered under this subsection. [WI Stat. 51.61 (1)]

Protective Equipment means a device that does not restrict movement when applied to any part of a person's body for the purpose of preventing tissue damage or other physical harm that may result from a person's behavior. Protective equipment includes but is not limited to helmets, gloves or mitts, goggles, pads worn on the body, and clothing or adaptive equipment specially designed or modified to restrict access to a body part. [DQA Definition]

Restraint means any device, garment or physical hold that restricts the voluntary movement of or access to any part of an individual's body **and** cannot be easily removed by the controlled individual. [Department Guidelines and Requirements for supporting People with Challenging/Dangerous Behavior]

Physical restraint includes all of the following [WI Stat. 50.035 (5) (a) 1.]:

a. A locked room.
b. A device or garment that interferes with an individual's freedom of movement and that the individual is unable to remove easily.
c. Restraint by a facility staff member of a resident by use of physical force.

Restrictive Measures include all of the forms of restraint, isolation, and protective equipment, etc.

Seclusion is a form of isolation in which the person is physically set apart by staff from others through the use of locked doors (HFS 94.02 (40), Wis. Admin. Code). Seclusion does not include the use of devices like "wander guards" or similar products that may also involve locking doors.

Unreasonable confinement or restraint includes the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his or her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the Department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint. [WI Stat. 46.90 (1) (i)]

APPENDIX B
Examples: Using Questions on Page 4 to Assist in Determining Abusive Restraints

Example 1

A young woman, living at home with her mother, receives assistance from personal care workers from morning until late afternoon. Upon a report, you found that once the care workers leave for the day, the young woman is kept in a bed enclosure until the next morning.

1.	Is the adult at risk being confined or restrained?	Yes
	What is the adult at risk doing that may require the use of restraint? Why do the caregivers believe that the restraint is needed?	The mother is concerned that her daughter will get into things around the apartment and could get herself into dangerous situations. The mother is not physically capable of moving or lifting her daughter.
	Is the restraint measure appropriate for the situation?	No. Restraint should not be used in lieu of adequate support.
	Is the device being used in a safe manner?	Not only are there concerns about the time spent in the enclosure but in the event of an emergency, the woman could not escape.
	How does the elder adult/adult at risk respond to the restraint?	Work with the mother and the young woman's caseworker (if she is a long-term care recipient) to recommend less restrictive alternatives than the enclosed bed.
2.	Does EA/AAR staff believe that the district attorney or law enforcement should be involved?	Unlikely. The situation is best handled by working with the mother and daughter.
3.	Is there a need for protective services? Is intervention needed? What is the best option for the elder adult/adult at risk? What other interventions are available? Could the caregiver transition down to less restraint or no restraint? What less restrictive interventions have been tried and demonstrated to be ineffective on managing the person's behavior?	
4.	Is the caregiver capable of changing to another intervention? Is it practicable given the situation, setting, and caregiver abilities?	

Result of Intervention:

Unfortunately, this situation has not been rectified in a meaningful manner. County workers hoped to find a new living arrangement for the daughter.

Example 2

A young woman is living with her family. During a CIP review, staff discovered that the family limited this young woman's existence to one room in the house. All care and basic needs are provided in this room. The young woman is very isolated: not allowed outside or out in the community except for medical appointments.

1.	Is the adult at risk being confined or restrained?	Yes
	What is the adult at risk doing that may require the use of restraint? Why do the caregivers believe that the restraint is needed?	The family felt that the young woman was very vulnerable and in danger outside the room.
	Is the restraint measure appropriate for the situation?	No.
	Is the device being used in a safe manner?	The room was not locked but the woman was in a wheelchair and not physically capable of opening the door by herself.
	How does the elder adult/adult at risk respond to the restraint?	
2.	Does EA/AAR staff believe that the district attorney or law enforcement should be involved?	Working with the family to improve the situation is a better first step.
3.	Is there a need for protective services? Is intervention needed? What is the best option for the elder adult/adult at risk? What other interventions are available? Could the caregiver transition down to less restraint or no restraint? What less restrictive interventions have been tried and demonstrated to be ineffective on managing the person's behavior?	
4.	Is the caregiver capable of changing to another intervention? Is it practicable given the situation, setting, and caregiver abilities?	It is likely, with more information or some assistance from a personal care worker, that other less restrictive alternatives could provide for her safety.

Result of Intervention:

The family initially allowed some personal caregivers to come in the home to assist. When her parents' health deteriorated, the young woman moved to an ICF/MR. A couple years ago, she moved into the community under the Relocation Initiative. She is living in a community setting and thriving. She has an active life in the community with no restraints or other restrictive measures in her present support plan.