The Patient Safety Education Program™
CANADA

Module 13d: Mental Health Care: Seclusion and Restraint: When All Else Fails

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Module 13d Mental Health Care: Seclusion and Restraint: When All Else Fails

PSEP – Canada Objectives	Related CPSI Safety Competencies
The knowledge elements include an understanding of: • the three typical categorizations of types of restraints; • how a "least restraint" approach can inform the use of behaviour management techniques; • the risks of restraint use to persons in care, staff, and others; • strategies for preventing the use of seclusion and restraint including the importance of a recovery model approach; and • how to manage a situation where restraints are needed. The performance elements include the ability to:	**Domain: Contribute to a Culture of Patient Safety** *1. Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:* 1.1. Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care 1.4. Demonstrate knowledge of policies and procedures as they relate to patient and provider safety, including disclosure 1.6. Participate actively in event and close call reporting, event analyses and process improvement initiatives 1.9. Recognize clinical situations that may be unsafe and support the empowerment of all staff to resolve unsafe situations 1.11. Advocate for improvements in system processes to support professional practice standards and the best patient care *2. Health care professionals who are able to describe the fundamental elements of patient safety, understand:* 2.1. Core theories and terminology of patient safety and the epidemiology of unsafe practices 2.3. The use of evaluative strategies to promote safety 2.5. Principles, practices and processes that have been demonstrated to promote patient safety 2.6. The nature of systems and latent failures in the trajectory of adverse events 2.9. The elements of a just culture for patient safety, and the role of professional and organizational accountabilities 2.10. The concept that health care is a complex adaptive system with many vulnerabilities, (e.g., space or workplace design, staffing, technology)

• develop strategies for working with persons in care, their families, and the care team to identify alternative strategies to restraint use; and • conduct an incident review following the use of restraint or seclusion.	*3. Health care professionals who maintain and enhance patient safety practices through ongoing learning:* 3.1. Identify opportunities for continuous learning and improvement for patient safety 3.3. Analyze a patient safety event and give examples on how future events can be avoided 3.5. Share information on adaptations to practices and procedures that increase safety for specific individuals or situations 3.7. Participate in self- and peer assessments reflecting on practice and patient outcomes *4. Health care professionals who demonstrate a questioning attitude as a fundamental aspect of safe professional practice and patient care:* 4.1. Recognize that continuous improvement in patient care may require them to challenge existing methods 4.2. Identify existing procedures or policies that may be unsafe or are inconsistent with best practices and take action to address those concerns 4.3. Re-examine simplistic explanations for adverse events to facilitate optimal changes to care 4.4. Demonstrate openness to change **Domain: Work in Teams for Patient Safety** *1. Health care professionals who participate effectively and appropriately in an interprofessional health care team to optimize patient safety are able to:* 1.2. Describe individual and team roles and responsibilities in the context of practice and in the health care system 1.3. Demonstrate respect for all team members, including the patient and his or her family 1.4. Work to develop a shared set of individual and team values, rights and responsibilities 1.5. Identify and act on safety issues, priorities and adverse events in the context of team practice 1.8. Contribute to a defined process for introducing new and emerging evidence into team-based

	care 1.10. Practice effective listening techniques to contribute to optimal teamwork and patient care *2. Health care professionals who meaningfully engage patients as the central participants in their health* *care teams:* 2.1. Ensure that patients are at the centre of care 2.2. Engage patients in decision-making and the management of their own health 2.3. Provide appropriate, sufficient and clear information, and teaching to patients to support informed decision-making 2.4. Advocate for individual patients and for the resources to be able to provide patient-centred, high quality care 2.5. Respond to individual patient needs and respect cultural and personal health beliefs and practices *3. Health care professionals who appropriately share authority, leadership, and decision-making for safer care:* 3.1. Explain their role in patient care to team members and patients 3.5. Encourage team members to speak up, question, challenge, advocate and be accountable to address safety issues and risks inherent in the system **Domain: Communicate Effectively for Patient Safety** *1. Health care professionals who demonstrate effective verbal and non-verbal communication abilities to prevent adverse events:* 1.1. Show respect and empathy in communication 1.2. Explain investigations, treatments and protocols clearly and adequately to patients

	1.3. Convey information with clarity appropriate to each patient (e.g., by using the Calgary-Cambridge model) 1.4. Convey information in structured communications to team members to promote understanding (e.g. ARC, CHAT, CUS, DESCscript, I'M SAFE, I PASS THE BATON, STAR) 1.5. Communicate in a manner that is sensitive to health literacy needs 1.6. Employ active listening techniques to understand the needs of others 1.7. Communicate in a manner that is respectful of cultural diversity 1.8. Respect privacy and confidentiality 1.9. Use a variety of communication tools and techniques to enhance and assess understanding on the part of patients and their families *2. Health care professionals who communicate effectively in special high-risk situations to ensure the safety of patients:* 2.1. Engage patients or substitute decision-makers in a discussion of risks and benefits of investigations and treatments to obtain informed consent 2.3. Communicate to others the urgency of a clinical situation 2.4. Employ communication techniques to escalate concerns across authority gradients to match the seriousness of the clinical situation 2.5. Employ appropriate communication approaches in high-risk situations, such as in clinical crises, emotional or distressing situations, and conflict 2.7. Demonstrate insight into their own communication styles with patients and team members in ordinary, crisis and stressful situations and adjust these styles appropriately to provide safe care *3. Health care professionals who use effective written communications for patient safety:*

	3.1. Provide appropriately detailed and clear written or electronic entries to the patient health record 3.2. Provide sufficient documentation to facilitate team members' comprehension of the patient's history, physical findings, diagnosis and rationale for the diagnosis, treatment and care plan at any time 3.4. Write patient care orders and prescriptions to convey the appropriate degree of urgency **Domain: Manage Safety Risks** *1. Health care professionals who recognize routine situations and settings in which safety problems may arise:* 1.1. Demonstrate situational awareness by continually observing the whole environment, thinking ahead and reviewing potential options and consequences 1.2. Recognize safety problems in real-time and respond to correct them, preventing them from reaching the patient 1.3 Employ, as appropriate, techniques such as diligent information-gathering, cross-checking of information using checklists, and investigating mismatches between the current situation and the expected state *2. Health care professionals who systematically identify, implement, and evaluate context-specific safety solutions:* 2.4. Reflect on the impact of an individual intervention, including the potentially harmful or unintended consequences of a safety intervention 2.5. Evaluate the ongoing success of a safety intervention by incorporating lessons learned 2.6. Adjust policies and procedures to reflect established guidelines, if applicable *3. Health care professionals who anticipate, identify and manage high-risk situations:*

	3.1. Recognize health care settings that may lead to high-risk situations 3.2. Respond effectively by means of efficient task and process management, crisis team functioning, and dynamic decision-making **Domain: Optimize Human and Environmental Factors** *1. Health care professionals who are able to describe the individual and environmental factors that can affect human performance understand:* 1.2. The role of attitude and professional culture in clinical practice *2. Health care professionals who apply techniques in critical thinking to make decisions safely are able to:* 2.1. Describe the common types of cognitive biases **Domain: Recognize, Respond to and Disclose Adverse Events** *2. Health care professionals who mitigate harm and address immediate risks for patients and others affected by adverse events and close calls:* 2.1. Assess the immediate safety and care needs for the physical and emotional well-being of patients and their families, and provide interventions as appropriate 2.2. Reduce or manage the risk of further harm to patients affected by adverse events and close calls 2.3. Provide appropriate support for individual health care professionals and teams involved in adverse events and close calls *3. Health care professionals who disclose the occurrence of an adverse event to patients and/or their families as appropriate and in keeping with relevant legislation:* 3.1. Understand what information should be disclosed at the initial disclosure stage, the time frame for disclosure, and the relevant documentation, reporting, and analyses

	3.2. Recognize the ethical, professional and legal obligation to disclose and report adverse events 3.3. Differentiate between disclosure and reporting and the inherent processes associated with each concept 3.4. Are aware of existing policies and procedures associated with disclosure and the extent to which these foster a culture of patient safety 3.5. Engage in honest communication and empathic dialogue with respect to disclosure 3.6. Recognize that there are situations that constitute special consideration regarding disclosure, for example, patients in vulnerable situations, patients who have a substitute decision-maker, patients with special communication requirements (e.g., those who are hearing impaired), and patients whose cultural perspective on disclosure differs from the provider's 3.10. Document unexpected outcomes, adverse events and the disclosure discussions 3.11. Provide ongoing follow-up as needed 3.12. Recognize the need for a just culture of safety in supporting disclosure and reporting 3.13. Appreciate the legal implications arising from disclosure *4. Health care professionals who effectively report the occurrence of an adverse event or close call:* 4.1. Recognize that the reporting of adverse events takes place across the continuum of care and includes primary, secondary and tertiary care centres *5. Health care professionals who participate in timely event analysis, reflective practice, and planning for the prevention of recurrence:* 5.1. Engage in personal and professional reflection regarding the adverse event 5.2. Recognize the importance of monitoring the outcome of event analysis 5.3. Apply lessons learned from the event analysis 5.4. Advocate for system change as warranted

Abstract

Restraint and seclusion are behavioural management interventions that should be used as a last resort to control a behavioural emergency. As discussed in *PSEP – Canada Module 13c: Mental Health Care: Diminishing Violence and Aggressive Behaviour,* a behavioural emergency is an instance of violence or aggressive behaviour that has yet to be "managed" (i.e, no intervention has been put in place so the behaviour is still present). Behavioural emergencies are often a manifestation of unmet health, functional, or psychosocial needs that can often be reduced, eliminated, or managed by addressing the conditions that produced them. **Restraints** include the use of physical force or mechanical devices to immobilize a person, as well as chemical restraints. **Seclusion**, a type of restraint, involves confining a person in a room from which the person cannot exit freely. Restraint and seclusion are not therapeutic care procedures. In fact, restraint and seclusion can induce further physical or psychosocial trauma. In short, these procedures pose a safety risk to the emotional and physical well-being of the person and have no known long term benefit in reducing behaviours. Thus, the position of this module is that any restraint should be considered an intervention of last resort and should, at most, only be used temporarily in a behavioural emergency.

Keywords

Restraint, seclusion, manual restraint, physical restraint, mechanical restraint, behaviourial emergency, least restraint, consent

Teaching methods

Didactic presentation, case study with small group discussion**.**

Objectives

The goal of this module is to situate the use of restraints in the larger context of a “least restraint” approach. This approach advocates that though restraint use may be needed during behavioural emergencies, it should be considered as an intervention of last resort. All the information discussed in this module should be understood in that light.

Knowledge requirements

The knowledge elements include an understanding of:

- how a “least restraint” approach can inform the use of behaviour management techniques;
- the three typical categorizations of types of restraints
- how to manage a situation where restraints are needed

- the risks of restraint use to persons in care, staff, and others; and
- strategies for preventing the use of seclusion and restraint including the importance of a recovery model approach

Performance requirements

The performance elements include the ability to:

- develop strategies for working with persons in care, their families, and the care team to identify alternative strategies to restraint use; and
- conduct an incident review following the use of restraint or seclusion.

Introduction

Rates of restraint and seclusion room use among persons with mental illness are not consistently reported across Canada. In Ontario, the Canadian Institute for Health Information (CIHI) has reported that about one quarter of persons admitted to inpatient mental health hospitals between 2006 and 2010 were restrained. Of those who were restrained, just over half were given a chemical restraint (58.9%), about a fifth were restrained by physical or mechanical means (20.7%), and another fifth were placed in seclusion (20.4%).

Restraints pose a major safety risk to both the person in care and staff. While effective in the short term to manage an incident of violent and aggressive behavior, restraining a person can have serious negative physical, social, and psychological effects as well as paradoxically, increase the risk of behavioural emergencies. Staff may be injured when trying to administer restraints sometimes severly enough to result in days off work. When applied, physical restraints can increase a person's risk of asphyxia, thrombosis, blunt trauma, cardiac difficulties, and death. Chemical restraint use has been associated with increased risk of respiratory depression or arrest, cardiovascular complications, seizures, neuroleptic malignant syndrome, and acute dystonia. Moreover, restraint use, particularly when employed on an ongoing basis, can be a major barrier to the person's recovery since the loss of control, social isolation, shame, and stigma can exacerbate feelings of despair and hopelessness. Additionally, environmental restraint, such as the use of seclusion rooms, results in increased suicidal ideation and physical self-harm.

As a last note, use of restraints may lead to the establishment of negative power relationships between staff and patients – where healthcare providers are viewed as controlling and holding power over the persons in care. This kind of perception undermines the ability to establish and maintain a good therapeutic rapport and enhances the risk that person in care experiences traumatization associated with the care environment

Types of restraint

"Restraint" can have different meanings and interpretations depending on the setting. In the mental healthcare context, "restraint" typically refers to the application of some level of restriction to physical movement, or state of mental awareness. Typically, restraints are divided into three categories:

- environmental,
- physical/mechanical, and
- chemical (sometimes referred to as Acute Control Medication (ACM)).

Though different forms of restraint may be needed to respond to a particular situation, it is important to note that no one form of restraint is less traumatizing than another. For all forms of restraint, once applied, close or continual observation and monitoring is required.

Restraints used as protective devices, (e.g., postural support, aid in treatment administration, protecting the person from falls and accidents, management of nonaggressive behaviour such as wandering) are used in non-emergency situations and are usually established within the person's care plan and consented to by the person or his/her substitute decision maker. The use of these restraints also poses risks to the person and require ongoing assessment and monitoring. For instance, physical restraints used to prevent falls are associated with weakness, muscle loss, and decreased balance and increased falling.

Environmental

Environmental restraint can include:

- limiting access beyond the unit (i.e., locked unit);
- limiting access beyond the patient's room (i.e., locked room); and
- placement of the patient in a separate room that is locked (i.e., seclusion).

Locked units are generally used to ensure the safety of persons at risk of harm to self or others by preventing them from leaving the unit except with appropriate supervision. In many instances, patients on locked units may be allowed to leave the unit once they have appropriately signed out at the nursing station.

A seclusion room is a specific and separate room that confines a patient and from which he or she cannot exit freely. They are used when a person is unable to control his or her violent emotions and there is the potential for immediate, harmful behaviour to self or to others. These rooms are designed to keep the person safe (i.e. they are free of hazards that the person could use to harm him or herself) and allow for observation by clinical staff. In some instances where separate seclusion rooms are not available, seclusion can also refer to confinement to the person's room.

Seclusion is a temporary measure and should not be used for persons who may be experiencing suicidal ideation or may otherwise be at risk of harm to themselves (e.g., banging head against wall). Seclusion may exacerbate their distress and causes of suicidal ideation. Similarly, it should not be used for persons who have medical conditions that require close monitoring (e.g. someone who has cardiac or respiratory issues and may experience subtle signs of physical distress that might be missed otherwise).

Physical restraint

Physical and manual restraints are never part of treatment. They are an intervention of last resort where the person's behaviour cannot be managed by any other means and there is a need for continued verbal interventions from staff to help calm the person. Extreme caution is needed in their application to prevent injury.

When a person is physically restrained, that person is physically/bodily held by others (e.g., care staff, security) to restrict his or her movement for a brief period of time, in order to calm the individual. This does not refer to holding a person in order to apply a mechanical restraint

Mechanical restraint

A mechanical restraint is a device or an appliance that restricts or limits freedom of movement. Such devices can include vest restraints, lap belts, pelvic restraints, chairs that prevent rising, wrist restraints, and sheets. Mechanical restraint is not temporary immobilization for medical reasons (e.g., splint), transportation (e.g., belt on stretcher), or devices for body position (e.g., harnesses for persons with paralysis).

Chemical restraint

In mental healthcare settings, there are instances where medications may be used to both treat symptoms and manage behaviourial emergencies. Therefore, *not included in the definition of chemical restraint are psychotropic medications that are used for treatment purposes as part of an ongoing plan of care for an established diagnosis*. Medication that is prescribed for PRN ("as needed") and established with the person as part of his or her plan of care is also excluded.

Chemical restraint or Acute Control Medication (ACM) therefore refers to the administration of psychotropic medication in situations where a person may have already lost behavioural control or where there is imminent risk of loss of control in behaviour that will lead to harm to self or others. Examples of ACMs include Lorazepam IM or Haloperidol IM.

Perceptions, patterns, and risks of restraint use

There is a myth in mental healthcare that restraint and seclusion are part of care. This myth was popularized by movies such as *One Flew Over the Cuckoo's Nest* (1975 American drama film) where restraint and seclusion were used by providers as part of the process of care. In some instances, restraints were also used to "protect" a person from themselves. In yet other instances, restraint were used automatically and proactively i.e. in the absence of any imminent violent or aggressive behaviour. And although this movie was made over 30 years ago, this perception persists – including in the minds of persons who are the recipients of care. For them, restraint and seclusion are viewed as part of a punitive system that controls and confines them.

In inpatient mental health settings, restraints should be used as an intervention of last resort to halt violent behaviour. Alternatively, these interventions of last resort can also be used to prevent escalation of agitated behavior or anger. In either circumstance, the interventions should be deployed immediately and, when possible, briefly.

The least restraint approach

The least restraint approach means that all possible alternative interventions to restraint are explored before deciding upon its use. Alternatives to restraints include de-escalation, redirection, setting limits, using timeouts, the use of medication to manage symptoms (not as a control procedure), psychosocial interventions, and safe physical escort techniques. When such alternatives are deployed early enough, the patient may respond positively to these less restrictive options. Responsibility for achievement of least restraint practice is shared with members of the healthcare team, clients, families, legal guardians, communities, agencies and governing bodies.

Many jurisdictions have implemented legislation that advocates for the minimization of restraint in care. For instance, the Ontario government passed Bill 85, the *Patient Restraints Minimization Act* that regulates when and how restraints may be used and addresses the principle of minimal restraint. In other provinces such as Alberta, Saskatchewan, Nova Scotia, and Quebec, professional practice position statements have been released focusing on the practice of least restraint and emphasizing the goal of restraint elimination. These position statements are founded on real-life, and often tragic evidence of the adverse outcomes from restraint. For instance, inquests into deaths related to the use of restraints have led to coroner's recommendations which state that facilities should provide restraint-free care and ensure greater involvement of patients and their advocates in managing risks that would ultimately lead to restraints. Above all else, these policies and position statements stress that restraint and seclusion are to never be used for punitive or threatening purposes.

Though a least restraint approach advocates that all alternatives to abate risk of harm should be exhausted before short-term restraint measures are implemented, it also

recognizes that sometimes restraint use is the only intervention to manage a behavioural emergency and maintain safety. That being said, organizations should be aware that restraint use has legal implications. Potential liability arising from restraint use and restraint use in the absence of informed consent are just two of the issues with which organizations may be faced.

Factors related to use of restraints

This section lists factors that have been found in research literature to be associated with higher rates of restraint. In many instances, the factors mirror those of violence or aggressive behaviour since behavioural emergencies are, by definition, an instance of violence or aggressive behaviour that has yet to be "managed". It is vital that these factors are not used to identify persons who should be restrained in behavioural emergencies; rather, they should be considered when developing alternative interventions. This section is meant to create awareness but not promote judgmental approaches to dealing with persons who may have characteristics associated with use of restraint.

Behaviours

A prior history of violence and aggressive behaviours is the most common factor predictive of restraint use among persons receiving inpatient mental health services. While this prior history suggests that the person is more likely to act out in distressing situations and thus increases the likelihood of restraint use, it is important that restraint not be the de facto care response.

Age and sex

Although violent behavior is related to age and sex, the key message regarding age and sex and the use of restraints is that the decision to consider restraint should not be based solely on these factors. Rather, the decision should rest on contextual factors specific to the behavioural emergency (e.g., failure of all other behaviour management strategies).

Cognitive/communication factors

Persons with impaired cognitive functioning, including those with delirium or dementia, may be more likely to exhibit behaviours that increase the likelihood of restraint. This is possibly due to the difficulty communicating distress and/or impaired cognitive performance. Research has shown that persons who are incapable of consenting to treatment, presumably due to cognitive deficits, are more likely to be restrained than those who can consent. This finding underscores the importance of involving substitute decision makers in the care planning process and identifying opportunities to avoid restraint.

Mental health and clinical symptoms

Persons with cognitive disorders such as dementia tend to experience the highest rates of restraint of all kinds in mental health settings – followed by persons with bipolar disorders and schizophrenia. All are much more likely to be restrained than persons with depression. This may be because the delusional thoughts or command hallucinations associated with these disorders may more frequently lead to agitated states.

Persons with substance use disorder or personality disorder are more likely to receive chemical restraint than other mental health conditions but no more likely to experience other forms of restraint.

Staff training and experience

Higher rates of restraint and seclusion use have been found where there is a lack of staff expertise and training as well as where staff perceive the need to exercise control. Attitudes of control among staff may stem from a lack of knowledge of alternative management strategies for behavioural emergencies or from assumptions or myths that staff believe justify the use of restraints. The following is a summary of ongoing myths and reality associated with restraint practices.

Table 1: Myths and realities associated with restraint (Mohr et al, 2003).

Myth:	Restraint and seclusion are used only to insure the safety of the person in care as well as other persons in care and staff.
Reality:	Restraints and seclusion are used mostly for loud, disruptive, or non-compliant (but not always violent) behavior.
Myth:	Restraint and seclusion are used only when there is no other alternative.
Reality:	In fact, research shows that restraint and seclusion continue to be the first and automatic response to difficult behavior. There is consensus, however, that restraint should be used as a last resort.
Myth:	Restraint and seclusion reduce patient and staff injuries.
Reality:	The use of restraint and seclusion actually increases the risk of patient and staff injuries.
Myth:	Restraint and seclusion help individuals feel secure, gain self-control, and learn to follow rules.
Reality:	There is no evidence to suggest that these interventions are effective therapeutic interventions.

In addition to ongoing belief in the above myths, increased use of restraint and seclusion in an organization may be attributed to the kind of care approaches and professional attitudes held by staff. Care approaches that fail to establish a therapeutic rapport with the

person, recognize the importance of trauma informed care, and lack an open communication process will lead to increased risk of behavioural emergencies and restraint use. (Care approaches are discussed in more detail in the PSEP – Canada Module 13 **Mental Health Care: An Introduction to Patient Safety Issues Module**)

The mental health team

The mental health team play a key role is the assessment, prevention and incident management with respect to the use of restraints.

Training

The clinical staff overseeing the care of the person must have specific training in:

- the assessment of risk of violence and aggressive behavior (the precursor to the possible use of restraint);
- identifying triggers for violence and aggressive behaviour;
- recognizing where a least restraint approach is inappropriate and where restraint must actually be deployed; and
- the management of behavioural emergencies.

This training should highlight:

- the signs and risk factors for behaviours;
- prevention strategies that promote patient choice; least restraint interventions for managing behaviours (e.g., de-escalation);
- strategies for maintaining personal safety and the safety of others; and
- procedures for debriefing and reporting behaviour incidents within a safe environment where a system level approach to incident management is supported.

The mental health team also is responsible for a number of activities to promote quality care. First, the team must understand the person's risk for behaviour, including unique factors that contribute to risk such as physical health symptoms, communication difficulties, and behaviour tendencies (e.g., yelling vs. hitting). This information combined with knowledge of environmental triggers (e.g., noise levels) is essential for optimally determining the need for restraints. Second, the team must collaborate with the person, his/her family and other healthcare providers to develop and implement the plan of care. For example, a confused person may benefit from occupational therapy as an environmental intervention that aids in orientation. This process of collaboration can solve potential problems and avoid restraint or seclusion use

Lastly, the mental health team must be aware of organizational policies regarding the use of restraints. Restraint use in response to behavioural emergencies may not be prescribed but implemented based on physician instruction. These policies also outline responsibilities for ongoing review and monitoring of restraint. For instance, it may be

the responsibility of the charge nurse to be responsible for ongoing use of restraint. This designated person should also be responsible for ongoing documentation, communications, and revisions to the plan of care.

Restraint initiation, monitoring and documentation

The use of restraints must comply with legislation within an organization's jurisdiction. Where present, the legislation should be the primary but preliminary resource for developing policies and procedures for the use of restraint or seclusion. Policy development should incorporate a least restraint approach with the safety and dignity of the person and staff as a guiding principle.

Where restraint use is being contemplated in response to a behavioural emergency, the points listed below are guidelines for their proper application.

Considerations prior to application of restraint

All possible options to halt or de-escalate behaviours should be explored before a restraint intervention is implemented. As discussed in detail in *PSEP – Canada Module 13c: Mental Health Care: Diminishing Violence and Aggressive Behaviour*, a number of strategies can be used to manage behaviourial emergencies. Some preventative strategies include:

- using calm, simple, clear, and reassuring directions when redirecting the person and removing environmental hazards and others from the immediate vicinity;
- providing the person with an opportunity to safely vent his or her emotions;
- providing calming environments or sensory interventions (e.g., comfort rooms) to help the person calm down;
- providing one-on-one intervention/supervision, as tolerated by the person. Persons who are agitated, restless, and pacing may be willing to be accompanied by a staff member while verbally releasing anger and frustration;
- avoiding speaking in loud, forceful, or urgent tones that may further aggravate the person;
- promoting a person-centred model of care where the person is actively involved in the decision-making process regarding his or her care and retains or regains his or her sense of self-determination.

Process of administering restraint

Generally, a physician's order is required to authorize restraint use on a person, regardless of the duration of the restraint. The order will include the physician's assessment and plan (type, duration, reason, anticipated outcome, etc.). In a behavioural emergency, restraints or seclusion may also be ordered by a senior clinical staff person including the attending psychiatrist, physician, or charge nurse. However, the roles and

limits with respect to restraint administration may vary by jurisdiction so it is important to follow appropriate legislation and organization policy.

Restraints should be in place for the shortest time possible. Orders for restraint typically expire after 24 hours. If the need for physical, mechanical, or environmental restraint continues beyond 24 hours, the attending/duty physician should reassess the patient and rewrite the order on a daily basis.

Administering a restraint (generally)

If all other behaviourial de-escalation measures fail and restraint must be applied, there are several steps that should be followed. These steps should be followed for all types of restraints.

- Communicate with the person about the type of restraint that will be applied and the reason for the restraint application. The staff member can give the person instructions on what he or she needs to do to avoid the use of restraint.
- Explain to the person what will happen when the restraint process begins.
- Protect the safety of the person's head and ensure that the patient is in a position that protects his or her ability to breathe (on back or side).

Administering chemical restraint

In addition to the process outlined above, when administering chemical restraint, other considerations need to be taken into account. Specifically, the person should be offered a chemical restraint in pill form but, given the nature of behavioural emergencies requiring restraint, an injection is most commonly used. To give the chemical restraint, some form of manual restraint may be needed. In these instances, the person should be informed of what will occur prior to applying manual and chemical restraint.

Introducing seclusion

Prior to introducing seclusion, the safety of the seclusion room should be ensured. In other words, the room should not contain furniture that could be moved or used as a weapon and the glass through which the person is monitored should be unbreakable. There should be a clearly marked exit and, when possible, a panic button that can be pressed for immediate help should be located in the room.

As in application of other kinds of restraint, the person should be informed of what is going to happen and why it is happening prior to its occurrence. The person should be apprised that he or she will be monitored for safety and that seclusion will stop when the person behaves in a way that no longer presents a risk of harm to self/others.

Monitoring the person

A person in restraint should be continuously monitored by audiovisual methods or by observation for changes in behaviour and signs of psychological trauma. It is considered appropriate to observe persons at frequently scheduled intervals (for example, every 15 minutes). According to legislation …Longer intervals between observations are considered unsafe.

The monitoring process includes an ongoing assessment of the person's vital signs, level of agitation as well as his/her risk of further violence or aggressive behaviour. Monitoring allows healthcare providers an opportunity to maintain contact with the person (visual presence and communication) during the episode where a restraint is in effect thereby reducing negative feelings about its use. This contact can include a full explanation of what procedures were performed, why they were performed, and how long they might last. Monitoring persons in physical restraints also involves checking if the restraints are too tight and whether the person needs to change positions.

Documentation

Even when not mandated by legislation, restraint interventions should be thoroughly and accurately documented to facilitate review of their use. Organizational policy should outline what information about the use of restraints should be documented. At a minimum, the duration of restraint use and the person's response to it should be documented.

In addition, the following are suggestions as to what should be documented when restraints are used:

- the circumstances leading to the incident (e.g., triggers and type of behaviour);
- alternatives to the restraint intervention that were attempted;
- reasons for the type of intervention;
- effectiveness of the intervention (e.g., immediate response, delayed de-escalation);
- the person's mental status before and following the use of the intervention;
- any emotional responses, such as an increase or a decrease in levels of agitation; anxiety, verbalizations of aggression or intent to harm self or others or expressions of a sense of hopelessness and loss of self-control;
- evidence of flashback to a traumatic event (esp. in those persons with a history of experiencing abuse); and
- the type and intervals of monitoring.

In instances where a chemical restraint/ACM was used, documentation should also include:

- The medication information (i.e., name(s), dosage, route, and time of administration); and

- Monitoring and documentation of vital signs, level of consciousness, changes in psychomotor activity, any medication side effect.

Prevention of restraint use

In order to promote a safe care environment it is important to implement restraint prevention strategies. Such strategies should focus on the model and culture of care provision, the appropriate assessment of the person, the nature of the care environment, and the skills of the care staff.

Approaches to care:

Recovery oriented care

Patients who are most at risk of being restrained or put into seclusion are often in a non-recovery state, i.e., their lives are in turmoil or state of breakdown leading to the need for hospitalization.

The recovery oriented approach to care supports instilling the value of choice above control for persons in care. This approach may prevent restraint and seclusion use. Some of the key steps to align organizational culture with a recovery based approach to reducing restraints include:

- instituting practices and procedures that are based on the recovery oriented care concepts;
- allowing flexibility in practice and procedure to meet individual needs in given circumstances;
- implementing person-centered approaches to care;
- instituting policies that encourage the organization to be innovative in its care approaches and to try new ways of providing care;
- instituting guidelines and policies that are user friendly, easy to understand, and easy to remember.

It is also important to recognize the barriers to changing an organization's culture to reflect a recovery oriented care approach. These may include staff prejudices and attitudes. For instance, clinical staff who consistently work with persons in a non-recovery state may develop a certain degree of hopelessness for these patients and may come to believe that recovery is not possible. This attitude contributes to the use of restraint or seclusion as a means of controlling the person rather than empowering the person. As another example, staff may fear treating patients who may have a history of violence or aggressive behaviour. The person in care is also fearful, either as a consequence of the nature of his/her condition or from a feeling of having no control over his/her life. A cycle is thus established where fear triggers aggressive behaviours from person in care and triggers staff to use restraints to manage those behaviours. Lack of

proper staff training is yet another stumbling block. Change should be aimed at helping staff understand and work within a recovery framework.

Trauma Informed Care:

Like recovery oriented care, trauma-informed care is an approach that recognizes that each person is unique in perspective and lived experience. Trauma-informed care further recognizes that for some, their lived experience may have been traumatic and that trauma shapes the way the person copes and functions. Moreover, this approach acknowledges that the delivery of care may unwittingly cause the person to relive the distress associated with that past trauma. Revisiting past trauma may be expressed as violence or aggressive behavior or suicidal ideation. Trauma-informed care is therefore an approach which can impact patient safety because it ensures that care is not having further adverse effects on the person and helps the person work through the recovery process. It is an approach that informs how care providers work with the person in the recovery process. (see PSEP – Canada Module 13 **Mental Health Care: An Introduction to Patient Safety Issues** for further details on Trauma Informed Care)

Risk assessment of the person

Risk assessment in the context of this module is the assessment of the person for a behavioural emergency. Understanding the person's risk for these behaviours is central to preventing the use of restraints. Early assessment of the person, including behavioral screening, is critical to identifying persons at risk of behaviourial emergencies and establishing a plan for behaviour management. Using tools to help inform the clinical assessment, a review can be performed identifying whether behaviours are the result of unmet needs in other, non-behavioural areas (for example, pain/discomfort, fatigue, hunger, thirst, fear, bowel/bladder, boredom, need to move around, overstimulation). Care planning can then implement alternative strategies to meet such needs. PSEP – Canada Module 13c**: Mental Health Care: Diminishing Violence and Aggressive Behaviour** contains more information on this process.

Care environment

Changes to the care processes and procedures as well as the physical care environment can reduce the risk of behavioural emergencies that lead to restraint use. Some example are below.

- Waking, retiring, meal and medication schedules may need to be adjusted to prevent agitation or confusion. One-on-one activities and variations in current activity schedules can also be considered.
- For older adults with cognitive impairment, wandering may lead to a harsh response by other patients, particularly if the person wanders into another person's room. The occupant may strike out or provoke a behaviour response of the wanderer. In such examples, care environments for persons at risk of

wandering can be designed to promote stimulation (e.g., art work or visual stimuli).
- Ensuring that room/unit capacity is appropriate (for example, avoiding overcrowding).

Alternatives to restraint use

Comfort rooms, or rooms with enhanced sensory stimulation, are an alternative to seclusion. They are designed with comfortable furniture, soothing colors, soft lights, quiet music, and other sensory aids. Their use has been shown to reduce restraint and seclusion room use in acute psychiatry units and has been associated with improved psycho-social outcomes. Though these rooms may not be appropriate in all instances e.g. a person who has lost all behavioural control, they may be the right approach for a person who may be at heightened states of agitation or for those in a behaviourial emergency who agree to safely engage in a comfort room as an alternative to restraint.

Other prevention strategies to consider include developing Safety Plans and recognizing the importance of sensory experiences and approaches, (refer to the RNAO Best Practice Guidelines on Alternative Approaches to the Use of Restraints whose link can be found in the Resource section of this module.)

Staff training

It is important that the organizational culture supports the minimization of restraints by providing resources to help staff implement early identification and preventative interventions for behaviour emergencies. Systems should be developed with input from physicians and other mental health professionals to help ensure meaningful compliance by all staff. Areas that should be covered in staff training in ongoing restraint prevention include:

- assessment and crisis prevention techniques;
- use of least restrictive methods;
- engaging and empowering persons and family in the care process;
- how to employ restraint and seclusion safely (including understanding the risks and benefits of either intervening or not intervening);
- process for continuously reevaluating the need for restraint or seclusion;
- process for continuous monitoring to ensure the person’s safety and other needs are met;
- appropriate prevention and response to behaviourial emergencies including the importance of maintaining safety of the person, other patients, and care staff;
- legal issues related to seclusion and restraint; and
- alternative behaviour management strategies.

Adequate staffing levels

Increasing trained staff to patient ratios is effective for reducing the incidence of restraint use and seclusion. This is possible because the increased number of staff per person on care improves the staff's ability to identify and diffuse potential behaviourial emergencies as well as the responsiveness of the unit to crisis situations. More frequent interactions between staff and patients can decrease the risk for behaviourial emergencies and, thus, restraint use and seclusions.

Continuity of care and therapeutic rapport

Maintaining the continuity of the care is important to ensure persons do not become confused or agitated. This can happen when there are inconsistent procedures, rules, or practices. It can also happen when there are frequent and unexplained changes of healthcare providers on a care team. A primary nursing care approach should be taken where one staff member is assigned to the same person during their time in care to build up an understanding of his or her individual strengths, preferences, needs, and idiosyncrasies. A sense of familiarity with a consistent caregiver can reduce and may even eliminate periods of abusive behaviour. This will also ensure that the care person and care team can identify risks of potential behaviour emergencies early to implement non-restrictive interventions to prevent escalation.

Incident management and review

As part of the quality improvement process, each incident of restraint use or seclusion should be reviewed as well as the process for ongoing monitoring of control interventions at the unit and hospital levels. The incident management process should include (some of the steps may be mandated by legislation):

- a debriefing process,
- incident reporting, and
- a formal incident review process (e.g., root cause analysis) in instances where the incident was deemed inappropriate or led to harm of the person or others.

Debriefing

The initial debrief is informal and should take place in the immediate aftermath of an incident and include both the care team and the person involved. The purpose of this debrief is to discuss:

- what happened;
- what alternative methods were attempted and failed; and
- what restraint method was ultimately used.

Incident reporting

Most organizations have a mechanism for formally reporting behaviourial emergencies that lead to incidents of restraint use. Sometimes called Unusual Occurrence Reports (UORs), the reports records:

- the date, the time, location of the incident;
- the nature of the incident and control interventions used;
- any details surrounding the nature of the incident (triggers, behaviours or verbalizations that occurred during the incident, etc.);
- persons involved in the incident (staff, patients, others); and
- outcomes from the incident (abatement of behaviour, injury, etc.).

Each organization should develop specific policies for documentation surrounding the use of restraints. The documentation should include the above points about the behavioural emergency as well as specific details about the restraint, including:

- the type of restraint used;
- the staff who ordered and applied the restraint;
- for chemical restraint, the type and dosage of medication;
- the monitoring and review process that was used while the person was in restraint;
- the total amount of time the person was in the restraint; and
- whether a debriefing was carried out with the person and other team members following the use of restraint.

Formal incident review

Teams are assembled in organizations to conduct reviews of adverse incidents such as behavioural emergencies leading to restraint use. The purpose of the review is to understand the potential factors that led to the use of restraint. Below are some of the questions that should be asked and answered to identify those factors.

- What is the person's history regarding treatment for psychiatric diagnoses?
- Did the person receive appropriate medication to manage mental health problems such as psychotic disorders or mania?
- Was the behaviour related to a new condition with sudden onset?
    - Acute medical conditions can result in delirium or acute psychotic episodes associated with behavioural change.
- Was behaviour aimed at the other person provoked or unprovoked?
    - Identifying triggers will assist in determining care plan interventions focused on preventing future abusive behaviours toward others.
    - If the violence or aggressive behaviour was not provoked, determine whether underlying medical or mental health problems are affecting the person's reactions to others.

The review should also include an evaluation of whether restraint or seclusion use was appropriate in the circumstances. Some the questions that may be asked to make this determination are:

- Were all other strategies for managing behaviours exhausted prior to implementing restraint or seclusion?
- Was there documentation in the person's chart about the person's preferences for restraint, if required? If so, was the person's preference respected?
- Was an in-person evaluation by a physician performed on a timely basis (for example, within 1 hour of initiation of the control intervention) after the restraint was applied?
- Was the patient's chart reviewed and were other team members consulted to determine the reason for the use of restraint?

Quality improvement

Standards of care that incorporate a least restraint approach should be the foundation for any quality improvement initiatives focused on re-education of healthcare providers or elimination of restraint and seclusion. When designing the specific organizational approach, the least restraint model should be based on jurisdictional legislation as well as recommended best practice.

Any policy for reduction and elimination for restraint use and seclusion must emphasize the importance of a safe workplace for staff and a safe environment for care of patients. Policy development should be done with the involvement of clinical staff so that any policy is based on feasible approaches to care. It is also important that appropriate resources be identified to support staff in achieving a restraint-free environment. Staff resources may include education about identified alternative strategies to restraint and seclusion, training on key principles within recovery and trauma-informed models of care, provision of appropriate risk assessment tools, allocation of appropriate staffing resources, and other practices and procedures that promote an environment that is supportive of alternatives to the use of restraints. It is also important to provide staff education about the assessment, planning, implementation, support and evaluation of least restraint practices and client rights. Simply telling staff not to use restraint or seclusion will not be effective.

Quality and performance indicators

Once policies are in place, mechanisms for evaluating the process and outcomes of restraint use should be established. A quality review team should exist within organizations to monitor and review various indicators of quality and safety. This group should review performance indicators for restraint and seclusion. These indicators can be defined and developed by examining the number of aggregate incident reports for physical, manual, and environmental restraints that occur within specific treatment units

within defined periods of time (e.g., weekly, monthly, quarterly, etc.). Historical trends (as revealed by internal data) could be used to establish a baseline to which improvement could be compared. Collected data should be used to inform practice and improve quality not as a punitive mechanism. Reports on performance indicators should be made available to all treatment units and staff members. These reports can serve to reinforce healthy competition between staff members as well as mechanisms for positive feedback and reinforcement.

While restraint reduction policies are becoming more prolific across Canadian mental health care organizations, provincial agencies responsible for health quality improvement have only recently started to monitor patient safety incidents for mental health, in general, and restraint use in particular.

Summary

In managing behavioural emergencies, restraint use should be the intervention of last resort since among other reasons, all forms of restraint have the potential to be traumatizing to the person. When it is used, restraint is most appropriately used to halt an ongoing incident where the person presents imminent risk of harm to self or others and cannot be managed in any other way. Moving an organization's patient safety culture to one of least or a non-restraint practice requires strong organizational leadership to support the transition.

Potential pitfalls

- An organizational culture that is not supportive of a least restraint model;
- Viewing restraints and seclusion as automatic and first responses to behaviour management;
- The failure to respond to behavioural emergencies using a person-centred approach that balances personal dignity with the need to safeguard other persons in care as well as care providers.

Pearls

- Organizations should strive to work with the person to establish preferred approaches to behaviour prevention and management;
- Recognition that adopting a recovery-oriented and trauma informed care model can prevent restraint use;
- The debriefing following all incidents of restraint and seclusion is an important opportunity to understand what happened and use the lessons learned to improve care processes.

Toolkits & outcome measures

Roadmap to a Restraint-Free Environment: This training manual, developed in the United States by the National Association of Consumer/Survivor Mental Health Administrators (NACSMHA) and published by the Substance Abuse and Mental Health Services Administration, is focused on a recovery based framework and was developed by consumers for training of direct care staff in inpatient facilities. http://www.nasmhpd.org/general_files/publications/ntac_pubs/R-S%20RISK%20MGMT%2010-10-06.pdf

Alternatives to Restraint and Seclusion in Mental Health Settings: Questions and Answers From Psychiatric Nurse Experts: An online article by Laura Stokowski written for Medscape Nurses: Nursing Perspectives. Provides information on definitions, restraint and seclusion alternatives, and organizational policy and staff considerations. http://www.medscape.com/viewarticle/555686

interRAI Mental Health Instrument and Control Interventions Clinical Assessment Protocol: This assessment tool combines a global mental health assessment of the person with specific approaches for identifying and managing persons at risk of restraint or seclusion.

Hirdes JP, Curtin-Telegdi N, Morris JN, Fries B, Rabinowitz T, et al. interRAI Mental Health Assessment Form and Users. *Manual for Inpatient Psychiatry. Version 9.1*. Washington, DC: interRAI, 2011.

Hirdes JP, Curtin-Telegdi N, Mathias K, Perlman C, et al. *interRAI Mental Health Clinical Assessment Protocols (CAPs) for use with community and hospital-based mental health assessment instruments. Version 9.1*. Washington, DC: interRAI, 2011.

http://catalog.interrai.org/

Resources

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- **Promoting Safety: Alternative Approaches to the Use of Restraints**, Registered Nurses' Association of Ontario, February 2012 http://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints

- Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion. American Psychiatric Association, American Psychiatric Nursing Association, National Association of Psychiatric Health Systems, 2003. http://www.naphs.org/rscampaign/learning.pdf

- Ashcraft L, Anthony W. Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatr Serv*. 2008 Oct;59(10):1198-202. http://www.recoveryinnovations.org/pdf/seclusion%20and%20restraint%20paper.pdf
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Module 13d Trainer's Notes

Principal message

The single most important message your audience should come away with is that any restraint should be considered an intervention of last resort and should, at most, only be used temporarily in a behavioural emergency. As a part of this insight, the participant should come away with key elements of restraint prevention strategies that can be implemented by a unit or organization to promote a safe care environment.

Module overview

Restraint and seclusion are behavioural management interventions that should be used as a last resort to control a behavioural emergency. A behavioural emergency is an instance of violence or aggressive behaviour that has yet to be "managed". Behavioural emergencies are often a manifestation of unmet health, functional, or psychosocial needs that can often be reduced, eliminated, or managed by addressing the conditions that produced them. Restraints include the use of physical force or mechanical devices to immobilize a person, as well as chemical restraints. Seclusion, a type of restraint, involves confining a person in a room from which the person cannot exit freely. Restraint and seclusion are not therapeutic care procedures. In fact, restraint and seclusion can induce further physical or psychosocial trauma. In short, these procedures pose a safety risk to the emotional and physical well-being of the person and have no known long term benefit in reducing behaviours. Thus, the position of this module is that any restraint should be considered an intervention of last resort and should, at most, only be used temporarily in a behavioural emergency.

This module reviews best practices related to restraints and use of seclusion with an emphasis on de-escalation and a culture of least restraint. Specifically, this module will discuss the risks of restraint use to persons in care, staff, and others and strategies for preventing the use of seclusion and restraint including the importance of a recovery model approach. In addition, how a "least restraint" approach can inform the use of behaviour management techniques is also discussed. Lastly, strategies for working with persons in care, their families, and the care team to identify alternatives to restraint use, as well as conducting an incident review following the use of restraint or seclusion are covered by this module.

This module is designed to build directly off of *PSEP-Canada Module 13c: Mental Health Care: Diminishing Violence and Aggressive Behaviour*.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation	35 minutes
Debrief about teaching methods	5 minutes
Summary	2-3 minutes
Post-test & Evaluation	5 minutes
Total	49-51 minutes

3. Number of slides: 16

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be

used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP - Canada Front Cover Page**;
- **PSEP - Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic**; and
- appendix material as relevant.

6. Equipment needs

- Projector and screen
- Computer and monitor
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video segments to assess which trigger tapes or portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time. You can use as your interactive components the trigger tape stimulated discussion and an interactive exercise. To foster discussion, ask participants for examples from their institutions or experiences. Ideally, the examples could be linked to one of the major teaching points.

Alternative style: case-based teaching

Use a case you are familiar with to include some case-based teaching. To help participants feel involved and invested, you may invite them to give you a case from their institution or experience. However, it is usually best to return to the case you know to draw out analytic points for teaching since you do not need to 'think on your feet' too much.

5. Key take-home points

1. The use of restraints and seclusion should be considered as an intervention of last resort;
2. It is important to understand how a "least restraint" approach can inform the use of behavior management techniques;
3. The importance of responding to behavioural emergencies using a person-centred approach that balances personal dignity with the need to safeguard other persons in care as well as care providers.
4. Recognition that adopting a recovery-oriented and trauma informed care model can prevent restraint use;
5. Develop strategies for working with persons in care, their families and the care team to identify alternative strategies to restraint use.
6. The debriefing following all incidents of restraint and seclusion is an important opportunity to understand what happened and use the lessons learned to improve care processes.

6. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

7. Debrief about the teaching method

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods

would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

8. Post-test/evaluation

Ask the participants to complete the post-test questions for this module and evaluate the session.