Emergency Use of Manual Restraints Policy
Ability Building Center

I. Policy

It is the policy of this DHS licensed provider (Ability Building Center) to promote the rights of persons served by this Ability Building Center and to protect their health and safety during the emergency use of manual restraints.

"Emergency use of manual restraint" means using a manual restraint when a person poses an imminent risk of physical harm to self or others and it is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own, do not constitute an emergency.

II. Positive support strategies and techniques required

A. Ability Building Center will attempt to implement the following positive support strategies and techniques to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others. Some of the following procedures could be used to de-escalate the situation and are options that could be implemented by staff. This is not a fully inclusive list of options that could be implemented.

Examples of positive support strategies that could be implemented :

- Follow individualized strategies in a person's coordinated service and support plan and coordinated service and support plan addendum;
- Shift the focus by verbally redirect the person to a desired alternative activity;
- Model desired behavior;
- Reinforce appropriate behavior
- Offer choices, including activities that are relaxing and enjoyable to the person;
- Use positive verbal guidance and feedback;
- Actively listen to a person and validate their feelings;
- Speak calmly with reassuring words, consider volume, tone, and non-verbal communication;
- Simplify a task or routine or discontinue until the person is calm and agrees to participate;
- Respect the person's need for physical space and/or privacy
- or remind the person served has options that they may choose to spend time alone, when safety permits, as a means to self-calm.
- Individualized strategies that have been written into the person's Coordinated Service and Support Plan (addendum) or Positive Support Transition Plan

B. Ability Building Center will develop a positive support transition plan on the forms, in the manner prescribed by the Commissioner and within the required timelines for each person served when required in order to:
   1. eliminate the use of prohibited procedures as identified in section III of this policy;

2. avoid the emergency use of manual restraint as identified in section I of this policy;
3. prevent the person from physically harming self or others; or
4. phase out any existing plans for the emergency or programmatic use of restrictive interventions prohibited.

III. Permitted actions and procedures

Use of the following instructional techniques and intervention procedures used on an intermittent or continuous basis are permitted by Ability Building Center. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum.

A. Physical contact or instructional techniques must be use the least restrictive alternative possible to meet the needs of the person and may be used to:
   1. calm or comfort a person by holding that persons with no resistance from that person;
   2. protect a person known to be at risk of injury due to frequent falls as a result of a medical condition;
   3. facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; or
   4. block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others, with less than 60 seconds of physical contact by staff; or
   5. to redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

B. Restraint may be used as an intervention procedure to:
   1. allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition; or
   2. assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm; or
   3. position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.
   Any use of manual restraint as allowed in this paragraph [Section B] must comply with the restrictions identified in [Section A].

C. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

IV. Prohibited Procedures

Use of the following procedures as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience, is prohibited by Ability Building Center:

A. Chemical restraint: "Chemical restraint" means the administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement and is not a standard treatment or dosage for the person's medical or psychological condition.

B. Mechanical restraint**:** "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.

Mechanical restraint does not include the following:

1. Devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement; or

2. The use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.

C. Manual restraint: "Manual restraint" means physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.

D. Time out: "Time out" means the involuntary removal of a person for a period of time to a designated area from which the person is not prevented from leaving. For the purpose of this policy, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de- escalation of behavior; nor does it mean taking a brief break or rest from an activity for the purpose of providing the person an opportunity to regain self-control.

E. Seclusion**:** "Seclusion" means:

1. Removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room; or

2. otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return**.**

F. Any aversive or deprivation procedure.

1. "Aversive procedure" means the application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior.

2. "Deprivation procedure" means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.

V. Manual Restraints Allowed in Emergencies

A. Ability Building Center allows the following manual restraint procedures to be used on an emergency basis when a person’s conduct poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety:

Ability Building Center

Examples that Ability Building Center could include:

- One Arm Hold
- One Hand Block to One Arm Hold
- Two Arm Block, Wrapping to a One Arm Hold
- One Arm Hold to Floor
- Choke Hold to One Arm Hold
- Floor Hold – Two Person
- A combination of any of the above.

*See appendix A for descriptions of how holds are performed.

B. Ability Building Center will not allow the use of a manual restraint procedure with a person when it has been determined by the person's physician or mental health provider to be medically or psychologically contraindicated. Ability Building Center will complete an assessment of whether the allowed procedures are contraindicated for each person receiving services as part of the service planning required under section 245D.070, subdivision 2, for recipients of basic support services; or the assessment and initial service planning required under section 245D.071, subdivision 3, for recipients of intensive support services.

VI. Conditions for Emergency Use of Manual Restraint

A. Emergency use of manual restraint must meet the following conditions:
   1. immediate intervention must be needed to protect the person or others from imminent risk of physical harm;
   2. the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety; and
   3. the manual restraint must end when the threat of harm ends.

B. The following conditions, on their own, are not conditions for emergency use of manual restraint:
   1. the person is engaging in property destruction that does not cause imminent risk of physical harm;
   2. the person is engaging in verbal aggression with staff or others; or
   3. a person's refusal to receive or participate in treatment or programming.

VII. Restrictions When Implementing Emergency Use of Manual Restraint

Emergency use of manual restraint must not:

A. be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury;
B. be implemented with an adult in a manner that constitutes abuse or neglect;
C. be implemented in a manner that violates a person's rights and protection;
D. be implemented in a manner that is medically or psychologically contraindicated for a person;
E. restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing;
F. restrict a person's normal access to any protection required by state licensing standards and federal regulations governing Ability Building Center;
G. deny a person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;
H. be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by Ability Building Center;

I. use prone restraint. "Prone restraint" means use of manual restraint that places a person in a face-down position. It does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible; or

J. apply back or chest pressure while a person is in a prone position, supine (meaning a face-up) position, or side-lying position,

K. be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

VIII. Monitoring Emergency Use of Manual Restraint

A. Ability Building Center must monitor a person's health and safety during an emergency use of a manual restraint. The purpose of the monitoring is to ensure the following:
   1. only manual restraints allowed in this policy are implemented;
   2. manual restraints that have been determined to be contraindicated for a person are not implemented with that person;
   3. allowed manual restraints are implemented only by staff trained in their use;
   4. the restraint is being implemented properly as required; and
   5. the mental, physical, and emotional condition of the person who is being manually restrained is being assessed and intervention is provided when necessary to maintain the person's health and safety and prevent injury to the person, staff involved, or others involved.

B. When possible, a staff person who is not implementing the emergency use of a manual restraint must monitor the procedure.

C. A monitoring form, as approved by the Department of Human Services, must be completed for each incident involving the emergency use of a manual restraint.

IX. Reporting Emergency Use of Manual Restraint

A. Within 24 hours of an emergency use of manual restraint, the legal representative and the case manager must receive verbal notification of the occurrence as required under the incident response and reporting requirements in the 245D HCBS Standards, section 245D.06, subdivision 1.

   When the emergency use of manual restraint involves more than one person receiving services, the incident report made to the legal representative and the case manager must not disclose personally identifiable information about any other person unless Ability Building Center has the consent of the person.

B. Within 3 calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the program's designated coordinator the following information about the emergency use:
   1. who was involved in the incident leading up to the emergency use of a manual restraint; including the names of staff and persons receiving services who were involved;
   2. a description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of a manual restraint;
   3. a description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the emergency use of a manual restraint was implement. This description must identify when, how, and how long the alternative measures were attempted before the manual restraint was implemented;

4. a description of the mental, physical, and emotional condition of the person who was manually restrained, leading up to, during, and following the manual restraint;
5. a description of the mental, physical, and emotional condition of the other persons involved leading up to, during, and following the manual restraint;
6. whether there was any injury to the person who was restrained before or as a result of the use of a manual restraint;
7. whether there was any injury to other persons, including staff, before or as a result of the use of a manual restraint; and
8. whether there was a debriefing with the staff and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident. Include the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned.

C. A copy of this report must be maintained in the person's service recipient record. The record must be uniform and legible.

D. Each single incident of emergency use of manual restraint must be reported separately. A single incident is when the following conditions have been met:
   1. after implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety;
   2. upon the attempt to release the restraint, the person's behavior immediately re-escalates; and
   3 staff must immediately re-implement the manual restraint in order to maintain safety.

X. Internal Review of Emergency Use of Manual Restraint

A. Within 5 business days after the date of the emergency use of a manual restraint, Ability Building Center must complete and document an internal review of the report prepared by the staff member who implemented the emergency procedure.

B. The internal review must include an evaluation of whether:
   1. the person's service and support strategies need to be revised;
   2. related policies and procedures were followed;
   3. the policies and procedures were adequate;
   4. there is need for additional staff training;
   5. the reported event is similar to past events with the persons, staff, or the services involved; and
   6. there is a need for corrective action by Ability Building Center to protect the health and safety of persons.

C. Based on the results of the internal review, Ability Building Center must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the program.

D. The corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

E. Ability Building Center has identified the following person or position responsible for conducting the internal review and for ensuring that corrective action is taken, when determined necessary:

Program Coordinator

XI. Expanded Support Team Review of Emergency Use of Manual Restraint

A. Within 5 working days after the completion of the internal review, the program must consult with the expanded support team to:
   1. Discuss the incident to:
      a. define the antecedent or event that gave rise to the behavior resulting in the manual restraint; and
      b. identify the perceived function the behavior served.
   2. Determine whether the person's coordinated service and support plan addendum needs to be revised to:
      a. positively and effectively help the person maintain stability; and
      b. reduce or eliminate future occurrences of manual restraint.

B. Ability Building Center must maintain a written summary of the expanded support team's discussion and decisions in the person's service recipient record.

C. Ability Building Center has identified the following person or position responsible for conducting the expanded support team review and for ensuring that the person's coordinated service and support plan addendum is revised, when determined necessary.

Program Manager

XII. External Review and Reporting of Emergency Use of Manual Restraint

Within 5 working days after the completion of the expanded support team review, the program must submit the following to the Department of Human Services using the online behavior intervention reporting form which automatically routes the report to the Office of the Ombudsman for Mental Health and Developmental Disabilities:

A. report of the emergency use of a manual restraint;
B. the internal review and corrective action plan; and
C. the expanded support team review written summary.

XIII. Staff Training

Before staff may implement manual restraints on an emergency basis Ability Building Center must provide the training required in this section.

A. Ability Building Center must provide staff with orientation and annual training as required in Minnesota Statutes, section 245D.09.
   1. Before having unsupervised direct contact with persons served by the program, the program must provide instruction on prohibited procedures that address the following:
      a. what constitutes the use of restraint, time out, seclusion, and chemical restraint;
      b. staff responsibilities related to ensuring prohibited procedures are not used;
      c. why such prohibited procedures are not effective for reducing or eliminating symptoms or undesired behavior;
      d. why prohibited procedures are not safe; and

e. the safe and correct use of manual restraint on an emergency basis according to the requirements in the 245D HCBS Standards, section 245D.061 and this policy.[1]

2. Within 60 days of hire the program must provide instruction on the following topics:[1]
   a. alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others;
   b. de-escalation methods, positive support strategies, and how to avoid power struggles;
   c. simulated experiences of administering and receiving manual restraint procedures allowed by the program on an emergency basis;[1]
   d. how to properly identify thresholds for implementing and ceasing restrictive procedures;[1]
   e. how to recognize, monitor, and respond to the person's physical signs of distress, including positional asphyxia;[1]
   f. the physiological and psychological impact on the person and the staff when restrictive procedures are used;[1]
   g. the communicative intent of behaviors; and[1]
   h. relationship building.[1]

B. Training on these topics received from other sources may count toward these requirements if received in the 12-month period before the staff person's date of hire or in the 12-month period before Ability Building Center's 245D-HCBS license became effective on Jan. 1, 2014.

C. Ability Building Center must maintain documentation of the training received and of each staff person's competency in each staff person's personnel record.

[1] Denotes items that are taught during PIA training

Policy reviewed and authorized by:

Print name & title _____ Signature _____

Date of last policy review: _____ Date of last policy revision: _____

Legal Authority: MS §§ 245D.06, subd. 5 to subd, 8; 245D.061

Appendix A

Instructions on Allowed Manual Restraint Procedures

One Arm Hold

- The one arm hold may be used to help you and the person manage aggression. This is generally done when there is a program support plan requiring it in a rare situation when there is a risk of injury.

- Move into position behind the person as you direct the arm being supported toward the front of the person, always maintaining contact with the elbow.

- In one continuous smooth movement, reach around the person's waist from the back with your other hand, staying between the person's arm and body, and secure the wrist that you have moved into the front position.

- With your two hands in place on the forearm, pull it against the person's ribs.

- Your thumbs should lie on top and parallel to the person's arm rather than wrapped in a grasp.

- The arm not being held against the body remains free unless it is used to aggress against you. In that event, you have two options:

  1. Duck your head to the side toward the person's shoulders. One of your shoulders should be bracing against the person's back and your feet should be in a wide stance to provide added support until the aggression stops, or

  2. If the person pinches or scratches with the unpinned arm, quickly let go of the wrist with your hand that is on the same side as the flailing arm, raise your elbow to the person's shoulder and slide it down to the waist, effectively capturing the person's arm. Replace your hand on the wrist of the other arm.

- If behavior continues to escalate, position your hip toward the individual's butt, establish footing and balance, and lean slightly back. This may prevent the person from dropping to the floor.

One Hand Block to One Arm Hold

Blocking anticipates and meets the blow from the other person.

- This is particularly useful if you initially have only one free hand for protection and the assailant is swinging wildly.

- Follow and deflect the person's jabs or slaps using one or both arms until you gain some composure.
- As the person throws a hit, reach out to the shoulder or elbow closest to you and slide your hand doen the outside of the amr, rotating the person away from you.
- Move immediately into a one arm hold.

Two Arm Block, Wrapping to a One Arm Hold

When you are able to use two arms to block:

- It is most effective to place your arms into a parallel (vertical or horizontal) or crossed position.
- Palms and the fleshy part of the forearms should be facing toward the other person.
- Remain in that position until you can either calm the person down and the hitting stops, or until it is obvious that you must protect yourself or others by placing the person into a one arm hold.
- To move from a block to the one arm hold, wait until the person strikes at you, reach out for the person's shoulder or elbow, rotating the person away from you and directing one of the person's arms to the front, near their waist. Continue to block with your free hand, slide around to the back of the person's body, and reach forward around the waist to grasp the forearm and move into a one arm hold.

One Arm Hold to Floor

PIA does not teach "take downs" and this technique should not be misconstrued as one. The One Arm hold to the floor is only used if the person loses balance or begins to drop while being assisted.

- If this should occur, maintain the one arm hold as you quickly back up and sit or kneel with the person onto the floor.
- At all times, keep your chin level, eyes straight ahead, and your back straight. Never hyperextend your neck, particularly as you assist a person to the floor.
- Ifpossible, release the person immediately and step away.
- If it would be dangerous to move away, firmly but calmly remain in that position until the situation is safe or until further escalation warrants more invasive strategies and assistance from additional staff.
- If thrashing or rocking occurs, pull slightly back, duck your head and brace your stronger shoulder against the person's back to stabilize and protect yourself.

Choke Hold to One Arm Hold

When someone is trying to choke you there is a significant potential for harm, and you may find it necessary to move immediately from the release into a one-arm hold. In those instances:

- Midway through your release from the chokehold, the wrist of the person would have been directed out and to the side.
- As that occurs, continue the movement further by rotating the person and moving in behind them.
- Reach through with your free hand to capture a wrist and move into the one arm hold.

Floor Hold – Two Person

This hold requires two or more people to accomplish safely.

- **Person One (Head Position)**
  - From the **One Arm Hold to Floor** position, move your legs to a kneeling position and then back up, assisting the person into a back-lying position until they rest face up on your upper legs. Remain in this position if the person's head is violently banging up and down.
  - When you can do so safely, separate your knees so the individual's head slides to the floor and immediately position your knees firmly on each side of the head, just above mid ear.
  - Press firmly inward with your knees so the head cannot turn our bounce on the floor.
  - Straighten your back and position your hands flat down on the shoulders or upper arms of the person.
  - ***NOTE: Never lock the person's head between your knees unless you have a second, trained staff ready to secure the lower part of the person's body at the same time.***

- **Person Two (Leg Position)**
  - Straddle (but do not sit on) the lower legs, facing the person's head so you can make eye contact with the other staff and with the person being held.
  - Your butt should be against the toes of the person, your knees firmly against the side of the person's calves pushing inward, your feet keeping the person's feet together, and your hands in an open "L" applying downward pressure just above each knee.
  - An alternate leg position would be to lay your belly across the lower thighs of the person. Give it your full weight and face the individual's head, keeping eye contact with the other staff.
  - NEVER USE THE LYING ACROSS POSITION WITH CHILDREN OR VERY SMALL ADULTS. In those cases, use a modified straddle position with your knees holding the child's feet together and your hands applying pressure just above the knees.
  - Take care with this hold that no undue pressure is placed on bones or joints.