



<b>Policy Name:</b>	<b>Emergency Use of Manual Restraints</b>
<b>Policy Code:</b>	<b>408</b>
<b>Policy Purpose:</b>	To specify when the emergency use of manual restraints is appropriate, identify the types of manual restraints that are allowable, and outline the procedures and documentation required when there is an emergency use of manual restraints.

## Section 1: Overview

**Rise only allows emergency use of manual restraint in circumstances in which a person is at imminent risk of harming themselves or others. Rise incorporates person-centered positive support strategies to promote environments of choice, independence, safety, and respect.**

This guide includes the following information regarding the emergency use of manual restraints:

- A. To identify categories of behavior that may require emergency use of a manual restraint.
- B. To identify manual restraints that **may be used** on an emergency basis.
- C. To identify manual restraints that **may not be used**.
- D. To outline the internal procedures to be followed relative to emergency use of a manual restraint.
- E. To outline the documentation and reporting requirements relative to the emergency use of a manual restraint.

## Section 2: Policy

This policy applies to all Rise team members and all persons receiving services through Rise.

- A. It is the policy of Rise to promote the rights of persons serviced by this program and to protect their health and safety during the emergency use of manual restraints.
- B. "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.
- C. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming, on their own, **does not** constitute an emergency.

## Section 3: Positive Support Strategies and Techniques Required

- A. The following positive support strategies and techniques must be used to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others:

1. Follow individualized strategies in a person's Support Plan.
  2. Shift the focus by verbally redirecting the person to a desired alternative activity.
  3. Model desired behavior.
  4. Positive reinforcement for desired behavior.
  5. Offer choices, including activities that are relaxing and enjoyable to the person.
  6. Use positive verbal guidance and feedback.
  7. Actively listen to a person and validate their feelings.
  8. Modify the environment to create a calm space by reducing sound, lights, and other factors that may agitate a person.
  9. Speak calmly with reassuring words, consider volume, tone, and non-verbal communication.
  10. Simplify a task or routine or discontinue until the person is calm and agrees to participate.
  11. Respect the person's need for physical space and/or privacy.
  12. If safe to do so, choose not to acknowledge the negative behavior.
- B. Should the use of less restrictive strategies not achieved safety, and a person still poses an imminent risk of harm to themselves or others, the following measures will be utilized:
- Continue to utilize the positive support strategies.
  - Continue to follow individualized strategies in a person's support plan and support plan addendum.
  - Ask the person and/or others if they would like to move to another area where they may feel safer or calmer.
  - Remove objects from the person's immediate environment that they may use to harm self or others.
  - Call 911 for law enforcement assistance if the alternative measures listed above are ineffective in order to achieve safety for the person and/or others. While waiting for law enforcement to arrive staff will continue to offer the alternative measures listed above if doing so does not pose a risk of harm to the person and/or others.
- C. The program will develop a positive support transition plan on the forms and in 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: Permitted Actions and Procedures**.
  2. Avoid the emergency use of manual restraint except as identified in **Section I: Policy**
  3. Prevent the person from physically harming self or others.
  4. Phase out any existing plans for the emergency or programmatic use of restrictive or aversive interventions.
- D. If any staff or program require specific case consults regarding a person served or their behavior, they will be encouraged to utilize our Supporting Overall Solutions (SOS) Committee, which promotes and assists with identifying and implementing individualized positive support strategies across Rise's service lines.

## Section 4: Permitted Actions and Procedures

- A. Any 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 or 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.
  - 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 team members or others.
  - 3. A person's refusal to receive or participate in treatment or programming.

### Monitoring Emergency Use of Manual Restraint

- C. The program 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. Allowed manual restraints are implemented only by team members trained in their use.
  - 3. The restraint is being implemented properly as required.
  - 4. 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, team members involved, or others involved.
  - 5. When possible, a team member who is not implementing the emergency use of a manual restraint must monitor the procedure.
  - 6. 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.

Use of the following instructional techniques and intervention procedures used on an intermittent or continuous basis are permitted by this program. When used on a continuous basis, it must be addressed in a person's Support Plan.

- A. Physical contact or instructional techniques must 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 person 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.
4. To 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 team members.
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 team members.

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.
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.
  - a. Note that this language **does** allow the use of manual restraint in certain situations such as a person running into a busy street. As always interventions should be done in the least restrictive manner possible.
3. Position a person with physical disabilities in a manner specified in the person's support plan and support plan addendum.
  - a. Any use of manual restraint as allowed in this paragraph [section B] must comply with the restrictions identified in [section A].
4. 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 constitute mechanical restraint.
5. In an emergency situation when a person's conduct poses imminent risk of harm to themselves or others *and* less restrictive strategies have not achieved safety, hold positions taught in Rise's Positive Supports training may be used.
  - a. Permitted procedures will be reviewed with team members during the orientation process and annually thereafter.

- D. 911 will be called for law enforcement assistance if the alternative measures listed above are ineffective to achieve safety for the person and/or others. While waiting for law enforcement to arrive, team members will continue to use the alternative measures listed above if doing so does not risk harm to the person and/or others.

## Section 5: Prohibited Procedures

- A. Use of the procedures listed below as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for team member convenience, is prohibited by Rise:

1. Chemical restraint: the administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement that is not a standard treatment or dosage for the person's medical or psychological condition.
  2. Mechanical restraint: the use of devices, materials, or equipment attached or next 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 triggered by a person's behavior.
  3. Manual restraint (except in an emergency): 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.
  4. Time out: removing a person involuntarily from an ongoing activity to a room, either locked or unlocked, or otherwise separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if the person chooses.
  5. Seclusion: the placement of a person alone in 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.
  6. Aversive procedures: the use of an aversive stimulus (punishment) in the event of a behavior for the purposes of reducing or eliminating the behavior.
  7. Deprivation procedures: the removal of a positive reinforcement following a negative behavior, resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that negative behavior.
- B. The program will not allow the use of manual restraint procedures with a person when it has been determined by the person's physician or mental health provider to be medically or psychologically contraindicated.
1. This program will complete an assessment whether the allowed procedures are contraindicated for each person receiving services as part of the service planning required under section 245D.071, subdivision 2, for recipients of basic services.
  2. The assessment and initial service planning required under sections 245D.70, subdivision 3, for intensive care support services.
  3. For those persons for whom manual restraint is contraindicated:
    - a. Continue to use positive support strategies.
    - b. Continue to follow individualized strategies in the Support Plan.
    - c. Ask the person if they would like to move to another area where they may feel safer or calmer.
    - d. Remove objects from the person's immediate environment that they may use to harm self or others.
- C. The following restraints are not allowed:
1. Picking up and/or carrying people.
  2. Prone (lying face down) restraint.

- D. Call 911 for law enforcement assistance if the alternative measures listed above are ineffective in order to achieve safety for the person and/or others. While waiting for law enforcement to arrive team members will continue to offer the alternative measures listed above if doing so does not pose a risk of harm to the person and/or others.
- E. Emergency use of manual restraint must not:
1. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury as defined in Rise's Maltreatment of Minors Reporting Policy.
  2. Be implemented with an adult in a manner that constitutes abuse or neglect as defined in Rise's Maltreatment of Vulnerable Adults Reporting Policy.
  3. Be implemented in a manner that violates a person's rights and protection.
  4. Be implemented in a manner that is medically or psychologically contraindicated for a person.
  5. 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.
  6. Restrict a person's normal access to any protection required by state licensing standards and federal regulations governing this program.
  7. Deny a person visitation or ordinary contact with legal counsel, a legal representative, or next of kin.
  8. Be used as a substitute for adequate staffing, for the convenience of team members, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by this program.
  9. Use prone restraint. "Prone restraint" means use of manual restraint that places a person in a face-down position. This 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.
  10. Apply back or chest pressure while a person is in a prone or supine (meaning a face-up) position.

## **Section 6: Team Member Training**

Before team members implement manual restraints on an emergency basis the program must provide the training required in this section.

- A. The program must provide team members 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. Team member 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 procedure are not safe.
    - 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.
  2. Within 60 days of hire the program must provide instruction on the following topics:
    - a. Alternative 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.
    - d. How to properly identify thresholds for implementing and ceasing restrictive procedures.
    - e. How to recognize, monitor, and respond to the person's physical signs of distress, including positional asphyxia.
    - f. The physiological and psychological impact on the person and the team members when restrictive procedures are used.
    - g. The communicative intent of behaviors.
    - h. Relationship building.
- B. Training on these topics received from other sources may count toward these requirements if received in the 12-month period before the team members date of hire or in the 12-month period before this program's 245D-HCBS license became effective on Jan. 1, 2014.
  1. Rise staff will be trained on accepted and prohibited procedures and alternative safety measures included in the Behavior Prevention and Intervention training. Topics covered include:
    1. Verbal Language
    2. Body Language
    3. Signs of anxiety & escalation
    4. Verbal De-escalation & Active Listening
    5. Setting Limits (options to give control)
    6. When a physical response is needed, demo & practice to ensure safety for all, including staff safety, redirection, and other Positive Support Strategies to mitigate potential harm.
    7. 911 calls as a last resort for imminent danger
    8. Incident Reports (purpose-importance/trends)

- C. The program must maintain documentation of the training received and of each team members' competency in each team members' personnel record.

Manual Restraints Not Allowed:

- A. Rise **will not allow** the use of an alternative safety procedure with a person when it has been determined by the person's physician or mental health provider to be medically or psychologically contraindicated. Rise 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, Subd. 2, for recipients of basic support services; or the assessment and initial service planning required under section 245D.071, Subd. 3, for recipients of intensive support service.

### **Section 7: Reporting Emergency Use of Manual Restraint**

As stated in this policy, Rise **only** allows emergency use of manual restraint in circumstances in which a person is at imminent risk of harming themselves or others. Any staff who has knowledge of a manual restraint being implemented must immediately report the incident to a manager or representative in QA. An incident report will be completed by a program manager or supervisor. Further reporting may be required in accordance with MN Statutes, Chapter 245D.061 and MN Administrative Rule 9544.0100.

- 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 the program has the consent of the person.
  - 2. Within 24 hours after an emergency use of a manual restraint, the team member who implemented the emergency use must report in writing to the program's designated coordinator the following information about the emergency use:
    - a. Who was involved in the incident leading up to the emergency use of a manual restraint; including the names of team members and persons receiving services who were involved.
    - b. 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.
    - c. 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.
    - d. 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.



- e. A description of the mental, physical, and emotional condition of the other persons involved leading up to, during, and following the manual restraint.
  - f. Whether there was any injury to the person who was restrained before or as a result of the use of a manual restraint.
  - g. Whether there was any injury to other persons, including team members, before or as a result of the use of a manual restraint.
  - h. Whether there was a debriefing with the team members 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.
  - i. A copy of this report must be maintained in the person's service recipient record. The record must be uniform and legible. That report will be scanned in and emailed to both the designated Vice President and Director of Quality Assurance.
- B. Each single incident of emergency use of manual restraint must be reported separately. A single incident is when the following conditions have been met:
- C. After implementing the manual restraint, team members attempt to release the person at the moment team members 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.
- 1. Upon the attempt to release the restraint, the person's behavior immediately re-escalates.
  - 2. Team members must immediately re-implement the manual restraint in order to maintain safety.

## **Section 8: Internal Review of Emergency Use of Manual Restraint**

- A. Within 5 business days after the date of the emergency use of a manual restraint, the Quality Assurance Specialist will complete the internal review/investigation of the report prepared by the team member who implemented the emergency procedure.
- 1. If the Quality Assurance Specialist is not able to complete this report the designated Vice President will assign someone to complete the internal review/investigation.
- 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 a need for additional team member training.
  - 5. The reported event is similar to past events with the persons, team members, or the services involved.

6. There is a need for corrective action by the program to protect the health and safety of persons.
- C. Based on the results of the internal review, the program 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.

### **Section 9: Expanded Support Team Review of Emergency Use of Manual Restraint**

- A. Within 5 working days after the completion of the internal review, the Designated Coordinator/Designated Manager (DC/DM) 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.
    - 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.
    - b. Reduce or eliminate future occurrences of manual restraint.
- B. The program must maintain a written summary of the expanded support team's discussion and decisions in the person's service recipient record.
- C. The DC/DM is responsible for conducting the expanded support team review and for ensuring that the person's CCSP-Addendum is revised, when determined necessary.

### **Section 10: External Review and Reporting of Emergency Use of Manual Restraint**

Within 5 working days after the completion of the expanded support team review, the DC/DM 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.
- C. The expanded support team review written summary.