

The Lutheran Home: Hope Residence Policy and Procedure  
on the Emergency Use of Manual Restraint

I. PURPOSE

The purpose of this policy is to promote service recipient rights and protect the health and safety of persons served during behavioral situations without the allowance of using an emergency use of manual restraint (EUMR). This policy will also promote appropriate and safe interventions needed when addressing behavioral situations.

II. POLICY

It is the policy of this The Lutheran Home: Hope Residence that emergency use of manual restraint is **not allowed** at any time. This policy contains content requirements of MN Statutes, section 245D.061, subdivision 9 for policy and procedures regarding emergency use of manual restraint. According to MN Statutes, section 245D.02, subdivision 8a, emergency use of manual restraint is defined as “using a manual restraint when a person poses an imminent risk of physical harm to self or others and 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 does not constitute an emergency.”

III. PROCEDURE

**Positive support strategies**

A. Hope Residence does not allow the emergency use of manual restraint. Hope Residence will attempt 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 include:

1. A calm discussion between the person served and direct support staff, nurse or supervisor regarding the situation, the person’s feelings, their responses, and alternative methods to handling the situation, etc. Staff should maintain a calm voice, talking with the person, not at. Staff should be receptive of the person’s statements of expressions of real, important, legitimate feelings.
2. A staff suggesting or recommending that the person participate in an activity they enjoy as a means to self-calm.
3. A staff to suggest or remind that the person served has options that they may choose to spend time alone, when safety permits, as a means to self-calm.
4. A staff suggesting alternatives to the behavior they are displaying versus protesting the behavior.
5. A staff offering choices whenever possible.
6. If the staff person wants the person to participate in one of their activities of daily living (shower, brush teeth, laundry, etc). the staff should ask

nicely versus demanding that they participate in the desired activity. A staff asking respectfully versus commanding.

7. A staff accepting the person's feeling rather than denying or rejecting their significance. It may be helpful to paraphrase the person's statements rather than discounting the person's feelings and attempt to understand them rather than trying to make the person stop feeling that way.
8. A staff person giving permission for the person to feel that way and suggest alternative ways of showing their frustrations.
9. A staff person teaching appropriate behavior.
10. A staff utilizing positive language (avoid no, don't, can't, never do that, stop that). Rather than stating what a person shouldn't do, state what the person can do.
11. A staff asking for assistance from another staff, who the person served may respond to more appropriately, as a means to calm.
12. The individualized strategies that have been written into the person's *Coordinated Service and Support Plan (CSSP)* and/or *CSSP Addendum*, or *Behavior Support Plan*.
13. The implementation of instructional techniques and intervention procedures that are listed as "**permitted actions and procedures**" as defined in Letter B of this **Positive support strategies** section.
14. A combination of any of the above.
15. If not other positive strategy or alternative measure was effective in de-escalating the person's behavior, staff will contact "911" for assistance.

**B. Permitted actions and procedures** include the use of instructional techniques and intervention procedures used on an intermittent or continuous basis. If used on a continuous basis, it must be addressed in the person's *CSSP Addendum*. These actions include:

1. Physical contact or instructional techniques that are the least restrictive alternative possible to meet the needs of the person and may be used to:
  - a. Calm or comfort a person by holding that person with no resistance from that person.
  - b. Protect a person known to be at risk or injury due to frequent falls as a result of a medical condition.
  - c. 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 or duration.
  - d. 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.
  - e. 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.
2. Restraint may be used as an intervention procedure to:
  - a. Allow a licensed health care professional to safely conduct a medical

examination or to provide medical treatment ordered by a licensed health care professional.

- b. 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.
  - c. Position a person with physical disabilities in a manner specified in their *CSSP Addendum*. Any use of manual restraint allowed in this paragraph must comply with the restrictions stated in the section of this policy **Restrictive Intervention**.
3. 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.
  4. Positive verbal correction that is specifically focused on the behavior being addressed.
  5. Temporary withholding or removal of objects being used to hurt self or others

### **Prohibited Procedures**

The company and its staff are prohibited from using the following:

- A. Chemical restraints
- B. Mechanical restraints
- C. Manual restraint
- D. Time out
- E. Seclusion
- F. Any other aversive or deprivation procedures
- G. As a substitute for adequate staffing
- H. For a behavioral or therapeutic program to reduce or eliminate behavior
- I. Punishment
- J. For staff convenience
- K. Prone restraint, metal handcuffs, or leg hobbles
- L. Faradic shock
- M. Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive
- N. Physical intimidation or a show of force
- O. Containing, restricting, isolating, secluding, or otherwise removing a person from normal activities when it is medically contraindicated or without monitoring the person served
- P. Denying or restricting a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as imminent risk of injury or serious damage has passed.
- Q. Painful techniques, including intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization, and degradation
- R. Hyperextending or twisting a person's body parts
- S. Tripping or pushing a person
- T. Requiring a person to assume and maintain a specified physical position or posture
- U. Forced exercise
- V. Totally or partially restricting a person's senses

- W. Presenting intense sounds, lights, or other sensory stimuli
- X. Noxious smell, taste, substance, or spray, including water mist
- Y. Depriving a person of or restricting access to normal goods and services, or requiring a person to earn normal goods and services
- Z. Token reinforcement programs or level programs that include a response cost or negative punishment component
- AA. Using a person receiving services to discipline another person receiving services
- BB. Using an action or procedure which is medically or psychologically contraindicated
- CC. Using an action or procedure that might restrict or obstruct a person's airway or impair breathing, including techniques whereby individuals use their hands or body to place pressure on a person's head, neck, back, chest, abdomen, or joints
- DD. Interfering with a person's legal rights, except as allowed by MN Statutes, section 245D.04, subdivision 3, paragraph (c).

**Restrictive Intervention:**

A restrictive intervention means prohibited procedures identified in MN Statutes, section 245D.06, subdivision 5; prohibited procedures identified in MN Rules, part 9544.006; and the emergency use of manual restraint.

A restricted procedure must not:

- A. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury as defined in MN Statutes, chapter 260E.
- B. Be implemented with an adult in a manner that constitutes abuse or neglect as defined in MN Statutes, section 626.5572, subdivisions 2 or 17.
- C. Be implemented in a manner that violates a person's rights identified in MN Statutes, section 245D.04.
- D. 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, or to any protection required by state licensing standards and federal regulations governing the program.
- E. Deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin.
- F. 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 of services provided by the company.
- G. Use prone restraint (that places a person in a face-down position).
- H. Apply back or chest pressure while a person is in the prone or supine (face-up) position.
- I. Be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

***Positive Support Transition Plans (PSTP)***

The company must and will develop a *Positive Support Transition Plan* on forms provided by the Department of Human Services and in the manner directed for a person served who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. A PSTP must be developed in accordance with MN Statutes, section 245D.06, subdivision 8 and MN Rules, part 9544.0070 for a person who has been subjected to three (3) incidents of EUMR within 90 days or four (4) incidents of EUMR within 180 days. This *Positive Support Transition Plan* will phase out any existing plans for the emergency use or programmatic use of restrictive interventions prohibited under MN Statutes, Chapter 245D and MN Rules, Chapter 9544.

**Alternative measures to be used because manual restraints are not allowed in emergencies**

- A. **Hope Residence does not allow the emergency use of manual restraint;** therefore, the following alternative measures must be used by staff to achieve safety when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety.
1. Staff will continue to utilize the positive support strategies as defined in the **Positive support strategies** section.
  2. If other persons served are in the immediate area of the person whose conduct poses an imminent risk of physical harm, staff will ask other persons to leave the area to another area of safety. If a person served is unable to leave the area independently, staff will provide the minimum necessary physical assistance to guide the person to safety.
  3. Objects, that may potentially be used by the person which would increase the risk of physical harm, will be removed until the person is calm and then immediately returned. These objects may include sharps, fragile items, working implements, etc.
  4. If the person's conduct continues to pose an imminent risk of physical harm to self or others, staff will call the mental health crisis line or mental health crisis intervention team (if available for the person) and follow any directions provided to them.
  5. If no other positive strategy or alternative measure was effective in de-escalating the person's behavior, staff will contact "911" for assistance.
  6. While waiting for law enforcement to arrive, staff will continue to offer the alternative measures listed here, if it remains safe to do so.

**Emergency use of manual restraint**

- A. If the positive support strategies were not effective in de-escalating or eliminating the person's behavior, emergency use of manual restraint may be necessary. To use emergency use of manual restraint, the following conditions must be met:
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.
  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.
  3. A person's refusal to receive or participate in treatment of programming.
- C. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, the company will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or

not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

**Monitoring of emergency use of manual restraint**

- A. Each single incident of emergency use of manual restraint must be monitored and reported separately. For this understanding, an incident of emergency use of manual restraint is a single incident 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 staff must immediately re-implement the restraint in order to maintain safety.
  
- B. During an emergency use of manual restraint, the company will monitor a person's health and safety. Staff monitoring the manual restraint procedure will not be the staff implementing the procedure, when possible. A monitoring form will be completed by the staff person for each incident of emergency use of manual restraint to ensure:
  - 1. Only manual restraints allowed according to 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.
  - 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.

**Reporting of emergency use of manual restraint**

- A. Reporting of the incident of emergency use of manual restraint will be completed according to the following process and will contain all required information per MN Statutes, sections 245D.06, subdivision 1 and 245D.061, subdivision 5.
  
- B. Within 24 hours of the emergency use of manual restraint, the company will make a verbal report regarding the incident to the legal representative or designated emergency contact and case manager. If other persons served were involved in the incident, the company will not disclose any personally identifiable information about any other person when making the report unless the company has the consent of the person.
  
- C. Within three (3) calendar days of the emergency use of manual restraint, the staff who implemented the emergency use of manual restraint will report, in writing, to the Designated Coordinator and/or Designated Manager the following information:
  - 1. The staff and person(s) served who were involved in the incident leading up to the emergency use of manual restraint.
  - 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 manual restraint.
  - 3. A description of what less restrictive alternative measures were attempted to de-

escalate the incident and maintain safety before the manual restraint was implemented. This description must identify the 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 restrained, and other persons involved in the incident leading up to, during, and following the manual restraint.
  5. Whether there was any injury to the person who was restrained or other persons involved, including staff, before or as a result of the manual restraint use.
  6. 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. The outcome of the debriefing will be clearly documented and if the debriefing could not occur at the time of the incident, the report will identify whether a debriefing is planned in the future.
- D. Within five (5) working days of the emergency use of manual restraint, the Designated Manager will complete and document an internal review of each report of emergency use of manual restraint. The internal review will include an evaluation of whether:
1. The person's served service and support strategies developed according to MN Statutes, sections 245D.07 and 245D.071 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 staff training.
  5. The reported event is similar to past events with the persons, staff, or the services involved.
  6. There is a need for corrective action by the company to protect the health and safety of the person(s) served.
- E. Based upon the results of the internal review, the company will develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by the individuals or the company, if any. The Designated Manager will ensure that the corrective action plan, if any, must be implemented within 30 days of the internal review being completed.
- A. Within five (5) working days after the completion of the internal review, the Designated Coordinator and/or Designated Manager will consult with the person's expanded support team following the emergency use of manual restraint. The purpose of this consultation is to:
1. Discuss the incident and to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served.
  2. Determine whether the person's served *Coordinated Service and Support Plan Addendum* needs to be revised to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.
- B. Within five (5) working dates of the expanded support team review, the Designated Coordinator and/or Designated Manager will submit, using the DHS online *Behavioral Intervention Reporting Form* (DHS-5148-ENG-1), the following information to the Department of Human Services and the Office of the Ombudsman

for Mental Health and Developmental Disabilities:

1. The report of the emergency use of manual restraint.
  2. The internal review and corrective action plan, if any.
  3. The written summary of the expanded support team's discussion and decision.
- C. The following written information will be maintained in the person's service recipient record:
1. The report of an emergency use of manual restraint incident that includes:
    - a. Reporting requirements by the staff who implemented the restraint
    - b. The internal review of emergency use of manual restraint and the corrective action plan, with information about implementation of correction within 30 days, if any
    - c. The written summary of the expanded support team's discussion and decision
    - d. The notifications to the expanded support team, the Department of Human Services, and the MN Office of the Ombudsman for Mental Health and Developmental Disabilities
  2. The PDF version of the completed and submitted DHS online *Behavioral Intervention Reporting Form* (DHS-5148-ENG-1). An email of this PDF version of the *Behavioral Intervention Reporting Form* will be sent to the MN-ITS mailbox assigned to the license holder.

### **Staff training requirements**

- A. Hope Residence recognizes the importance of having qualified and knowledgeable staff that are competently trained to uphold the rights of persons served and to protect persons' health and safety. All staff will receive orientation and annual training according to MN Statutes, section 245D.09, subdivisions 4, 4a, and 5. Orientation training will occur within the first 60 days of hire and annual training will occur within a period of 12 months.
- B. Within 60 calendar days of hire, the company provides orientation on:
1. The safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 or successor provisions, and what constitutes the use of restraints, time out, and seclusion, including chemical restraint; and
  2. Staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, MN Rules, part 9544.0060, or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe.
- C. Before staff may implement an emergency use of manual restraint, and in addition to the training on this policy and procedure and the orientation and annual training requirements, staff must receive training on emergency use of manual restraints that incorporates the following topics:
1. 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.
  2. De-escalation methods, positive support strategies, and how to avoid power

- struggles
3. Simulated experiences of administering and receiving manual restraint procedures allowed by the company on an emergency basis
  4. How to properly identify thresholds for implementing and ceasing restrictive procedures
  5. How to recognize, monitor, and respond to the person's physical signs of distress including positional asphyxia
  6. The physiological and psychological impact on the person and the staff when restrictive procedures are used
  7. The communicative intent of behaviors
  8. Relationship building.
- D. For staff that is responsible to develop, implement, monitor, supervise, or evaluate positive support strategies, the staff must complete a minimum of eight (8) hours of core training from qualified individuals prior to assuming these responsibilities. Core training must include the following:
- a. De-escalation techniques and their value
  - b. Principles of person-centered service planning and delivery and how they apply to direct support services provided by staff
  - c. Principles of positive support strategies such as positive behavior supports, the relationship between staff interactions with the person and the person's behavior, and the relationship between the person's environment and the person's behavior
  - d. What constitutes the use of restraint, including chemical restraint, time out, and seclusion
  - e. The safe and correct use of manual restraint on an emergency basis, according to MN Statutes, section 245D.061
  - f. Staff responsibilities related to prohibited procedures under MN Statutes, section 245D.06, subdivision 5; why the procedures are not effective for reducing or eliminating symptoms or interfering behavior; and why the procedures are not safe
  - g. Staff responsibilities related to restricted and permitted actions and procedure according to MN Statutes, section 245D.06, subdivisions 6 and 7
  - h. Situations in which staff must contact 911 services in response to an imminent risk of harm to the person or others
  - i. Procedures and forms staff must use to monitor and report use of restrictive interventions that are part of a *Positive Support Transition Plan*
  - j. Procedures and requirements for notifying members of the person's expanded support team after the use of a restrictive intervention with the person
  - k. Understanding of the person as a unique individual and how to implement treatment plans and responsibilities assigned to the license holder
  - l. Cultural competence
  - m. Personal staff accountability and staff self-care after emergencies.
- E. Staff who develop positive support strategies, license holders, executives, managers, and owners in non-clinical roles, must complete a minimum of four (4) hours of additional training. Function-specific training must be completed on the following:
- a. Functional behavior assessment
  - b. How to apply person-centered planning
  - c. How to design and use data systems to measure effectiveness of care



