Opportunity Matters Inc.

POLICY AND PROCEDURE ON 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 the 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 organization to ensure the correct use of emergency use of manual restraint, to provide intense training and monitoring of direct support staff, and to ensure regulations regarding the emergency use of manual restraint are followed. 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 do not constitute an emergency."

III. PROCEDURE

Positive support strategies

A. The organization 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. Engage the person to voice their concerns about the situation.
   2. Validate the emotions reported by the person
   3. Encourage the person to explore and evaluate a range of possible solutions to resolve the situation.
   4. Have a calm discussion with the person served regarding the situation, the person's feelings, their responses, and alternative methods to handling the situation, etc.
   5. Make a suggestion or recommendation that the person served participates in an activity they enjoy as a means to self-calm.
   6. Make a suggestion or remind the person served that they have options that they may choose to spend time alone, when safety permits, as a means to self-calm.
   7. Use individualized strategies that have been written into the person's *Coordinated Service and Support Plan (CSSP)* and/or *CSSP Addendum,* or *Positive Support Transition Plan*.
   8. Use 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.
   9. 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.
   10. Objects, that may potentially be used by the person that may be used 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.
   11. Use combination of any of the above.

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 organization 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 organization.
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 organization 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.

Emergency use of manual restraint (EUMR)
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. **The organization allows certain types of manual restraints which may be used by staff on an emergency basis**. **Detailed instructions on the safe and correct implementation of these allowed manual restraint procedures are included at the end of this policy**. Permitted manual restraints include the following:
1. Interim Controlled Position
2. Children's Control Position
3. Basket Hold to a Seated Position
4. Manual Escort
5. Two-Arm Hold
6. Two-Person Carry
7. **Handle with Care** – Primary Restraint Technique (PRT)
8. **Handle with Care** - Modified PRT for Very Small Children
9. **Handle with Care** - Two-Person Escort Technique

D. 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 organization 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 organization 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 organization 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 organization will not disclose any personally identifiable information about any other person when making the report unless the organization 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 organization to protect the health and safety of the person(s) served.

E. Based upon the results of the internal review, the organization 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 organization, 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.

F. 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 *CSSP 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.

G. 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.

H. 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. The organization 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 organization 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 organization 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 are responsible to develop, implement, monitor, supervise, or evaluate positive support strategies, *Positive Support Transition Plans*, or *Emergency Use of Manual Restraint*, 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:
   1. De-escalation techniques and their value
   2. Principles of person-centered service planning and delivery and how they apply to direct support services provided by staff
   3. 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
   4. What constitutes the use of restraint, including chemical restraint, time out, and seclusion
   5. The safe and correct use of manual restraint on an emergency basis, according to MN Statutes, section 245D.061
   6. 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
   7. Staff responsibilities related to restricted and permitted actions and procedure according to MN Statutes, section 245D.06, subdivisions 6 and 7
   8. Situations in which staff must contact 911 services in response to an imminent risk of harm to the person or others
   9. Procedures and forms staff must use to monitor and report use of restrictive interventions that are part of a *Positive Support Transition Plan*
   10. Procedures and requirements for notifying members of the person's expanded support team after the use of a restrictive intervention with the person
   11. Understanding of the person as a unique individual and how to implement treatment plans and responsibilities assigned to the license holder
   12. Cultural competence
   13. 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:
   1. Functional behavior assessment
   2. How to apply person-centered planning
   3. How to design and use data systems to measure effectiveness of care
   4. Supervision, including how to train, coach, and evaluate staff and encourage effective communication with the person and the person's support team.

F. License holders, executives, managers, and owners in non-clinical roles must complete a minimum of two (2) hours of additional training. Function-specific training must be completed on the following:
   1. How to include staff in organizational decisions
   2. Management of the organization based upon person-centered thinking and practices and how to address person-centered thinking and practices in the organization
   3. Evaluation of organizational training as it applies to the measurement of behavior change and improved outcomes for persons receiving services.

G. Annually, staff must complete four (4) hours of refresher training covering each of the training topics listed in items D, E, and F listed above.

H. For each staff, the license holder must document, in the personnel record, completion of core training, function-specific training, and competency testing or assessment. Documentation must include the following:
   1. Date of training
   2. Testing or assessment completion
   3. Number of training hours per subject area
   4. Name and qualifications of the trainer or instructor.

I. The license holder must verify and maintain evidence of staff qualifications in the personnel record. The documentation must include the following:
   1. Education and experience qualifications relevant to the staff's scope of practice, responsibilities assigned to the staff, and the needs of the general population of persons served by the program; and
   2. Professional licensure, registration, or certification, when applicable.

IV. DETAILED INSTRUCTIONS ON ALLOWED MANUAL RESTRAINT PROCEDURES

If an emergency use of manual restraint is needed, staff will attempt to verbally calm the person down throughout the implemented procedure(s), unless to do so would escalate the person's behavior. The least restrictive manual restraint will be used to effectively handle the situation.

Interim Control Position

Face the same direction as the individual. Grasp the individual's wrist of the arm closest to your body with your same hand (meaning your right hand grasps their right wrist). Bring the individual's arm across your body with their palm facing your body. Reach under the individual's arm with your opposite arm and grasp their opposite wrist over the top so their palm faces their body. Keep your hip snug with their hip. This position is not meant to be a transfer position. Staff should never attempt to move an individual while using the interim control position.

Children's Control Position

This position is designed to be used with children. Staff should only use this position with individuals considerably smaller then themselves.

Gain control of the individual's arms from behind and cross the arms in front of the individual. The arms should be positioned high on the person's upper chest and secured by locking one arm under the other. This will prevent the individual from slipping through and will minimize and pressure of the individual's chest or abdomen. Position yourself behind the individual while maintaining close body contact and standing to one side. This position allows you to maintain a balanced stance while managing the individual.

Basket Hold to a Seated Position

Begin with the Children's Control Position. Once staff has the individual's arms in position, staff will take a large step backwards and sit the individual on their bottom with their legs out in front of them. Staff will then kneel on one leg which is positioned behind the individual's back.

Manual Escort

Two staff will approach the individual on either side, facing the same direction. Staff will grasp the individual's wrist, palms facing up. Staff will hug the individual's arm close to their body. Staff will use their free hand to grasp their own wrist. Staff will hug their hips into the individual's hips to reduce movement. Staff will then walk at the same pace, moving the individual forward.

Two Arm Hold

2 arm restraint: (starts with 1 staff)

- Staff will use the "C" of their hand above the individual's elbow and other hand will be on their hip (to prevent them from turning on staff.)
- Remember to never squeeze or put pressure on the upper arm.
- With the "C" hand, push that arm in front of the individual's body.
- Staff's opposite foot should be between the individual's feet.
- Keep the other hand on the person's hip.
- When you have brought their arm in front of their body, secure their wrist with the hand that was on their hip.
- Your hand that was in the "C" position will go through the inner part of their elbow (palm facing out when going in to place) and secure their forearm.
- If the free hand does not cause any trouble then let it remain free.
- If the person starts to scratch or pry staff's hands off, staff then secure the free arm.
- Staff should stand more to the side of the arm that is being held- not the free arm.
- It is important that staff always use the hand that is on the forearm to secure the second hand.
- Never let go of the wrist hand to secure the 2nd hand.
- Keep your head down to prevent a head-butt.
- Keep your stance strong and keep them close to your body.

2nd staff assist with free arm

- To get the other arm: 2nd staff will always approach from the back. Start with both hands at the shoulder of the individual.
- Slide the lower hand into the "C" position.
- Bring the arm across the individual's body. Staff that has hold will release hand they have on forearm and secure the wrist that is being brought across.
- Staff should be talk to each other know that they have secured the correct person's arm. If not needed 2nd staff can step away from restraint at this point.

2 person upright restraint:

- After 1st person has both wrists, the 2nd staff will put their front hand around the individual and secure to the upper arm of the 1st staff.
- The 2nd staff's front leg will go in front of the knee of the individual to prevent further movement of that leg.

Side-lying restraint (if individual drops while in an upright 2 arm restraint):

- As you are going down, go to the direction of the hand that is closest to the individual's body.
- As you are going to the side, you will pull your low hand up into the individual's arm pit so that you don't have anything under the rib area. Your shoulder will be against their shoulder.
- Should the person roll into a prone position, roll them back as soon as possible using their front arm.
- If you are unable to roll them back, it is important to release so that you don't keep them in the prone position.

Two Person Carry

Two staff must be involved to implement the Two-Person Carry

- Staff will stand on either side of the person and place their nearest arm between the person's forearm and side. Staff will grasp the person's wrist with this arm and support the weight of the upper body with their forearm.
- Staff will then use their other arm to support the person's knee by interlocking their hand with the opposing staff's.
- Staff will begin the lift by crouching and counting from one to three.
- Staff will lift the person from the ground on the count of three and proceed to carry them to the appropriate location.
- Staff may not transport the person while in this position either up or down steps or stairways.
- If at anytime during the procedure the person attempts to stand on their own, staff will release the legs at the

same time.

- If the person then continues to walk on their own, staff will release the arms at the same time.

Handle with Care:

The following instructions **may not be used** as a substitute for formal certification by an authorized instructor. Staff must be trained and certified by an OMI Handle with Care Instructor before using the following restraints.

Handle With Care – Primary Restraint Technique (PRT)

While facing the person from the front or side; hook your arm under the person's same-side arm (i.e. matching Left-Left or Right-Right) between their forearm and shoulder blade (Figure 1a).

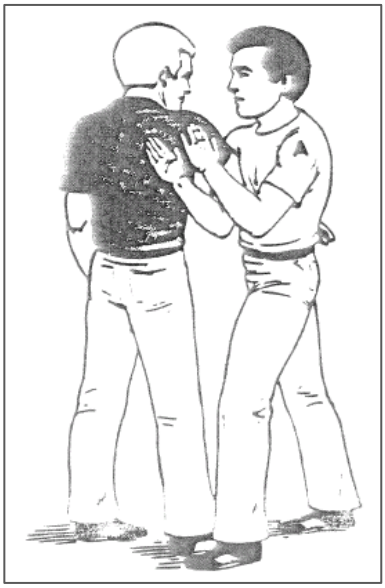


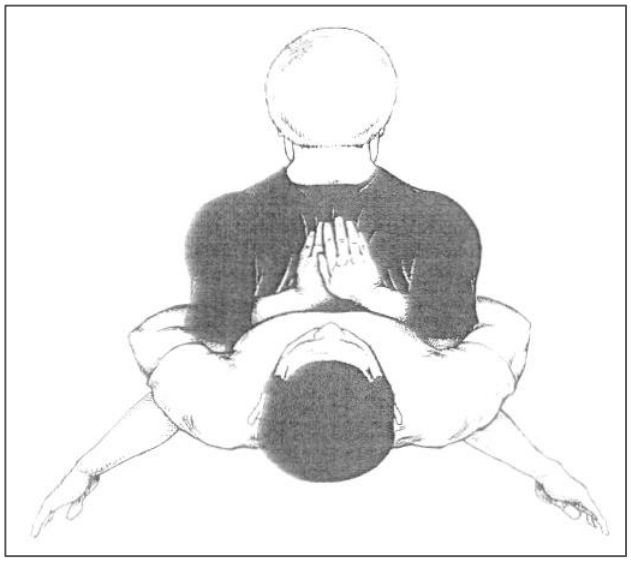
Figure 1a

Follow through to extend the palm of that hand until it rests, fingers pointing upward, against the center of the person's back, between their shoulder blades. Repeat the same procedure using the other matching arms, until your second palm is resting against the back of your first hand (Figure 1b).

Your elbows must be located above the level of the person's own elbows. Your feet should be slightly more than shoulder-width apart. Keep your back straight and head upright, using your hands as an anchor to prevent the person from striking with the back of their head. When positioned correctly; the restraint should rely on the paired alignment of each person's skeletal position, rather than the muscular strength of the staff.

Modified PRT for Very Small Children

When the staff who is implementing the EUMR is of considerably larger height than the person receiving it (> 1 ft.); it may be necessary to modify the position of the staff's arms, so that the first arm performing the "hooks" extends past the center of the person's body and that hand secures the person's upper arm above the elbow (Figure 2).



The fingers and thumb of that first hand should remain on the same side of the arm, with the palm facing towards the staff. Once secured, the second arm should wrap around the front of the person's torso, below their chest, yet above the stomach.

Figure 1b

Figure 2

Two-Person Escort Technique

The Two-Person Escort Technique may be used to transfer a person to a safe location, or as a means of transferring a PRT from one staff to another. To perform the Two-Person Escort Technique; both staff will approach the person from the face or side and simultaneously implement the standard PRT "hooks" with the arm matching that of the side of the person they happen to be on. Unlike the standard PRT, their hands will rest just above the person's shoulder blades with palms facing away from the person (Figure 3a). While facing the same direction as the person, each staff will secure the same forearm using their second hand. The staff's hands should grasp just above the person's wrists (Figure 3b).

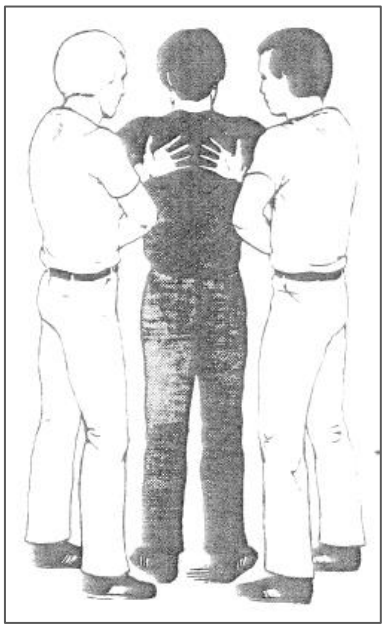


Figure 3a

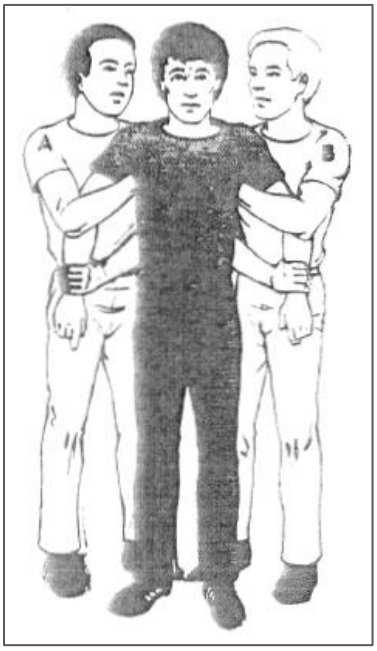


Figure 3b

While in this position, the staff may transport the person, without resistance, from one location to another, using non-confrontational verbal prompts to explain to the person each subsequent step. When approaching a doorway, the staff will pivot 180 degrees so as to continue the transport backwards through the threshold, returning to a forward-facing position to continue the transport. This occurs to minimize the risk of instability should the person attempt to lift their feet to meet the door frame during a forward-facing transfer. The transport should never occur on a stairway, in either direction.

When necessary, the Two-Person Escort Technique and the single-person Primary Restraint Technique (PRT) can be interchanged seamlessly between one another (e.g. should the person resist or escalate during a transport). While in the Two-Person Escort Technique; staff "A" will prompt staff "B" to "pass to me." In one motion, staff "A" will release the person's wrist and use that hand to perform their second standard PRT "hook," while staff "B" will release their hand behind the person's shoulder blade and step slightly to the side. During the transfer, staff "B" will continue to grasp the person's wrist until staff "A" has successfully completed and secured their second "hook" (Figure 3c).

Should a transport be needed from a standard PRT; the order of these steps will be reversed; with staff "B" securing the person's wrist, before stepping in for their "hook" as staff "A" moves their hand to grasp the person's opposite wrist.

Figure 3c