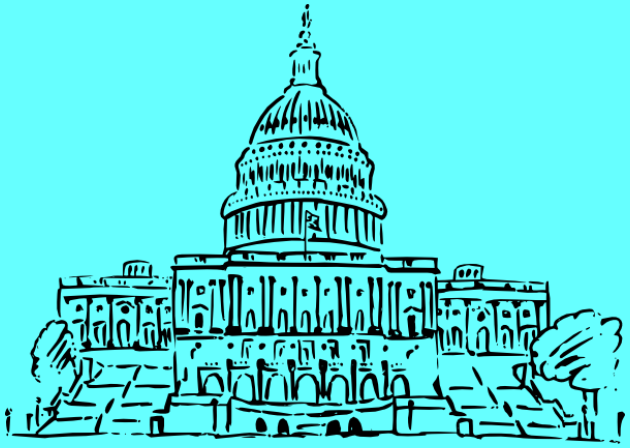
PAI'S Behavior Management Practices & Emergency Use of Manual Restraint (EUMR) Policy

What you need to know to provide support



Part I

AN OVERVIEW OF MINNESOTA ADMINISTRATIVE RULES CHAPTER 9544 - POSITIVE SUPPORT STRATEGIES AND RESTRICTIVE INTERVENTIONS

- Replaces old Rule 40.
- Establishes methods, procedures and standards to be used by providers governed by this Rule for the use of positive support strategies with persons receiving services.
- Includes additional requirements, prohibitions and constraints related to use of restrictive interventions.

What is this all about?

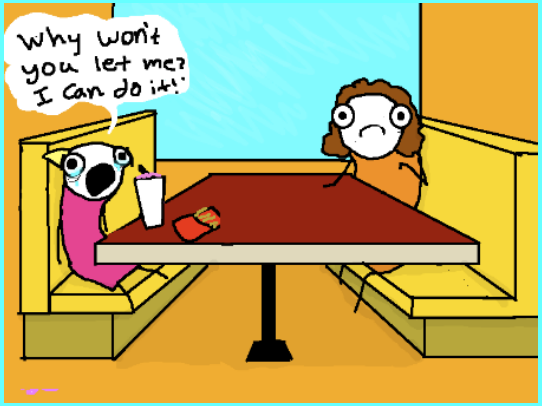
How does Rule 9544, in conjunction with 245D licensing standards, impact service delivery at PAI?

- These statutes and rules stipulate how we can and cannot respond to challenging behaviors.
- Additionally, they assign specific reporting requirements to service providers in the event a manual restraint is used.

So – Is something is changing?

- How we think about people?
- How we think about what they need?
- How we think about what services we should provide?

You and I



You reside.	I am a resident.
You move in.	I am admitted.
You are rude.	I have behavior problems.
You don't like being told what to do.	I am non-compliant.
When you ask someone out it is a date.	When I ask you out to dinner, it is an outing.
You didn't speak to your best friend for a month after they read your journal.	I don't know how many people have read the progress notes people write about me. I don't even know what is in there.
You forget to record withdrawals from your account. The bank calls to remind you.	I make mistakes during my check writing program. Someday, I might get a bank account.
Your family threw a surprise party.	I celebrated my birthday yesterday with five other residents and two staff members. I hope my family sends me a card.
Your doctor gave up telling you.	I am on a special diet because I am five pounds over my ideal body weight.
You hate housework.	I am learning household skills.
Your shirt says you are a "couch potato."	I am learning leisure skills.
You haven't decided what you want out of life.	My case manager and other professionals set goals for me for next year.
You will move onward and upward.	Someday I will be discharged . . . Maybe.

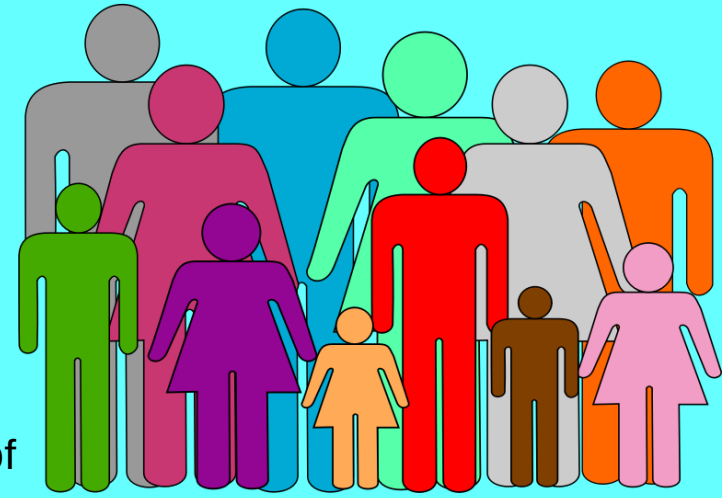
• Elaine Popovich, MoTASH

Purpose of the Positive Support Rule (9544.0005)

The purpose of these rules is to improve the quality of life of persons receiving home and community-based services by:

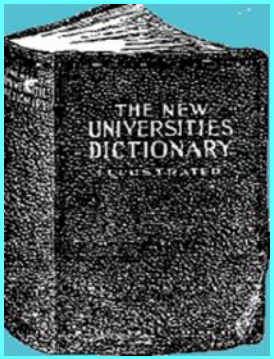
- promoting community participation, person-centeredness, an a approach that focuses on supporting persons receiving services in the most integrated setting;
- focusing on creating quality environments and lifestyles as primary responsibilities;
- ensuring collaborative, team-based development of positive support strategies;
- providing training to improve the person's skills and facilitate the person's ability to meet self-identified goals;
- increasing the person's self-determination abilities so the person may engage in community activity to the greatest degree reasonably attainable;

Purpose of the Positive Support Rule (9544.0005) continued…



The purpose of these rules is to improve the quality of life of persons receiving home and community-based services by:

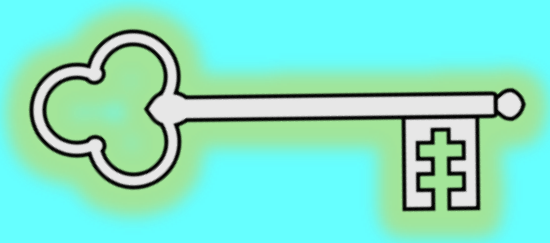
- developing specific support programs that promote outcomes valued by the person, the person's family, and the community to help the person receiving services to improve the person's quality of life;
- ensuring people are free from humiliating and demeaning procedures;
- eliminating all uses of aversive and deprivation procedures;
- creating a consistent set of standards for license holders to respond to behavior across licensed services and settings; and
- building staff knowledge and competence about the development and implementation of positive behavioral supports, person-centered planning and community integration.



It's all given to interpretation so … let's review some of the definitions that are central to positive support strategies and the restrictive intervention constraints.

Rule 9544

- **"Self-determination"** means the person makes decisions independently, plans for the person's own future, determines how money is spent for the person's supports, and takes responsibility for making these decisions. If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act.
- **"Domains of a meaningful life"** means community membership; health, wellness, and safety; own place to live; important long-term relationships; control over supports; and employment earnings and stable income.
- **"Person-centered planning"** means a strategy used to facilitate team-based plans for improving a person's quality of life as defined by the person, the person's family, and other members of the community, and that focuses on the person's preferences, talents, dreams, and goals. It is part of a family of approaches to organizing and guiding community change in alliance with people with disabilities and their families and friends.
- **"Positive support strategy"** means a strengths-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skills or alternative strategies and behaviors without the use of restrictive interventions.



Key Concepts

- **Person-centered Principles**
  - The provision of services that reflect the person's strengths, preferences, and daily needs. Activities are focused on the accomplishment of their goals.
- **Person-centered Planning**
  - Includes life planning with the person placed at the center of the planning process and the person's preferences and choices reflected in the selection of services and supports;
  - Involves the person directly with the person's community, network of connections, and close personal relationships that build on the person's capacity to engage in activities and promote community life; and
  - Identifies goals to support the person in the most integrated setting.

Major Provisions in the Positive Support Rule (9544) Impacting PAI Services:

- **Develop/document positive support strategies for every person.**
- **Maintain policy on the Emergency Use of Manual Restraint (EUMR).**
- **Adhere to prohibitions on use of restrictive interventions.**
- **Develop Functional Behavior Assessments as needed.**
- **Develop Positive Support Transition Plans as needed.**
- **Maintain staff qualifications and training.**
- **Report EUMR using the Behavior Intervention Report Form (BIRF).**

The Difference between Positive Support Transition Plans and Positive Support Strategies:

Positive Support Transition Plans per 245D and Rule 9544

245D.02, Subd. 23b. Positive support transition plan means the plan required in 245D.06, Subd. 8 to be developed by the expanded support team to implement positive support strategies to:

(1) eliminate the use of prohibited procedures as identified in section 245D.06, Subd. 5;

(2) avoid the emergency use of manual restraint as identified in section 245D.061; and

(3) prevent the person from physically harming self or others.

Includes specific form (6810B) and standards for creation, implementation, review and termination.

9544.0070, Subp.3 The license holder must develop a positive support transition plan per 245D.06, Subp. 8, for a person who has been subjected to three incidents of emergency use of manual restraint within 90 days or four incidents of EUMR within 180 days.

Positive Support Strategies per 245D and Rule 9544

245D.02, Subp. 41. Positive support strategy means a strengths-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skills or alternative strategies and behaviors without the use of restrictive interventions.

9544.0030, Subp. 1 The license holder must use positive support strategies in providing service to a person. These positive support strategies must be incorporated in writing to an existing treatment, service or other individual plan required of the license holder. At least every six months, the license holder must evaluate with the person whether the identified positive support strategies currently meet the standards in subpart 2 (**specific standards listed**). Based upon the evaluation, the license holder must determine whether changes are needed in the positive support strategies used, and, if so, make appropriate changes.

Positive Support Transition Plans are Required to:

- Phase out any existing plans for the emergency or programmatic use of restrictive interventions prohibited in Rule 9544.

- To eliminate the use of prohibited procedure, avoid the use of EUMR and prevent the person from physically harming self or others.

The Use of Positive Support Strategies is Mandated for Every Person Receiving Services

9544.0030, Subp. 2

To develop and implement positive support strategies, the license holder must:

- Assess the person's strengths, needs and preferences to identify and create a positive support strategy;
- Select positive support strategies that:
- are evidence-based,
- are person-centered,
- are ethical,
- integrate the person into the community,
- are the least restrictive to the person, and
- are effective.

Positive Support Strategies – 9544 Rule requirements apply to all facilities and services licensed under chapter 245D, and all licensed facilities and licensed services serving persons with a developmental disability or related condition.

Part II

Eliminating the Potential Use of Aversive or Deprivation Procedures

Consider the Person First!

- *Strengths and preferences*
- *Daily needs & activities*
- *Accomplishment of their goals*

What is the person communicating?

1. Is the interfering behavior a symptom of a medical disorder?

A person with a neurological disorder may strike out when becoming excited due to involuntary movements or poor muscular control.

"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. 18-19. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

Could the interfering behavior be caused by medical concerns or illness?

Common interfering behaviors & speculations about their causes

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Biting side of hand/whole mouth	• Sinus problems • Ears/Eustachian tubes • Eruption of wisdom teeth • Dental problems • Paresthesia/painful sensations (e.g., pins & needles) in hand
Biting thumbs/objects with front teeth	• Sinus problems • Ears/Eustachian tubes
Biting with back teeth	• Dental • Otitis (ear)
Fist jammed in mouth/down throat	• Gastroesophageal reflux • Eruption of teeth • Asthma • Rumination • Nausea
General Scratching	• Eczema • Drug effects • Liver/renal disorders • Scabies • Bed bugs
Head Banging	• Pain • Depression • Migraine • Dental • Seizure • Otitis (ear ache) • Mastoiditis (inflammation of bone behind the ear) • Sinus problems • Tinea capitis (fungal infection in the head) • Hearing internal voices

"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. 19-21. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

Common interfering behaviors & speculations about their causes

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Intense rocking/preoccupied look	• Visceral pain • Headaches • Depression • Dissociative Disorder
Odd un-pleasant masturbation	• Prostatitis • Urinary tract infection • Candida vagina • Pinworms • Repetition phenomena, PTSD
Pica – ingesting inedibles	• General: OCD, hypothalamic problems, history of under-stimulating environments • Cigarette butts: nicotine addiction, generalized anxiety disorder • Glass: suicidality • Paint chips: lead intoxication • Sticks, rocks, other jagged objects: endogenous opiate addiction • Dirt: iron or other deficiency state • Feces: PTSD, psychosis
Scratching/hugging chest	• Asthma • Pneumonia • Gastroesophageal reflux • Costochondritis/"slipped rib syndrome" • Angina
Scratching stomach	• Gastritis • Ulcer • Pancreatitis (also pulling at back) • Porphyria (bile pigment that causes, among other things, skin disorders) • Gall bladder disease

Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. Table 2: " Common interfering behaviors and speculations about their causes." 19-21. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

Common interfering behaviors & speculations about their causes

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Self-restraint/binding	• Pain • Tic or other movement disorder • Seizures • Severe sensory integration deficits • PTSD • Paresthesia
Stretched forward	• Gastroesophageal reflux • Hip/back pain • Back pain
Sudden sitting down	• Atlantoaxial dislocation (dislocation between the vertebrae in the neck) • Cardiac problems • Seizures • Syncope/orthostasis (fainting or light-headedness caused by medications or other physical conditions) • Vertigo • Otitis (thrown off balance by problems in the ear)
Uneven seat	• Hip pain • Genital discomfort • Rectal discomfort
Walking on toes	• Arthritis in ankles, feet, hips or knees • Tight heel cords
Waving fingers in front of the eyes	• Migraine • Cataract • Seizure • Rubbing caused by blepharitis (inflammation of the eyelid) or corneal abrasion

Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. Table 2: " Common interfering behaviors and speculations about their causes." 19-21. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

Common interfering behaviors & speculations about their causes

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Waving head side to side	• Declining peripheral vision or • Reliance on peripheral vision
Whipping head forward	• Atlantoaxial dislocation (dislocation between the vertebrae in the neck) • Pain in hands/arthritis
Won't sit	• Akathisia (inner feeling of restlessness) • Back pain • Rectal problem • Anxiety disorder

"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. Table 2: " Common interfering behaviors and speculations about their causes." 19-21. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

What is the person communicating?

2. **Is the quality of the person's life acceptable** (in their opinion) **in terms of personal relationships, personal choices or living situation, etc.?**

"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. 18-19. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

What is the person communicating?

3. **Is the interfering behavior influenced by medications they are taking (intended effects, side effects, etc.)?**



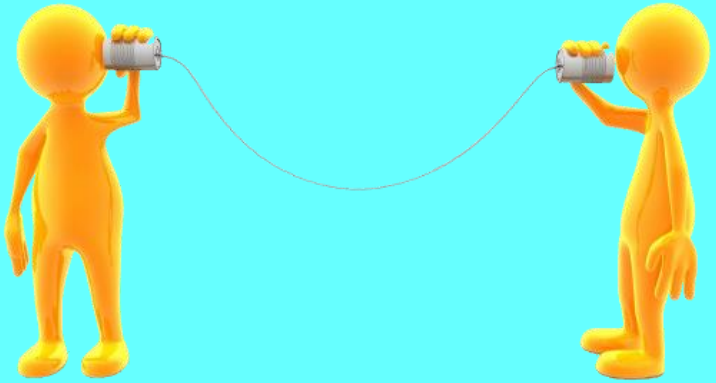

Example: anticholinergic medications have side effects may that result in an increase in pacing and leg movements, which can resemble anxiety.

"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. 18-19. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

What is the person communicating?

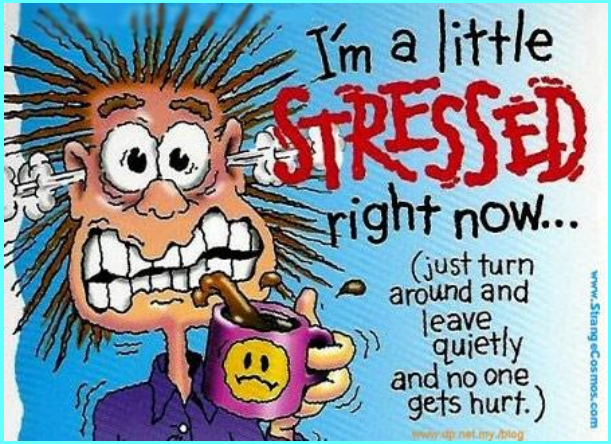
4. Is the interfering behavior part of a cluster or chain of related behaviors?

Example: if a person does not want to go to work, the person may refuse to get up, pretend to be sick, run away or attack others. If so, one intervention may solve many challenges.
If not, priorities will have to be set because trying to change many different behaviors at the same time is likely to cause confusion and reduce the chance for success.



"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. 18-19. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

What is the person communicating?



5. Is the behavior influenced by a lack of a skill or skills?

Often interfering behaviors occur because of a missing skill. If a person is asked to do something that he or she does not understand or is unable to do, the person may become frustrated and strike out or hurt him or herself to make the demand go away. Similarly, a person who hasn't developed coping skills may have difficulty handling stressful situations.

"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. 18-19. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

What is the person communicating?

6. Is the behavior a part of their behavioral phenotype?

A “behavioral phenotype” is a pattern of behavior, learning, or a personality trait typically seen among people with a specific genetic condition. Examples:

- Persons with Down syndrome have a characteristic personality, socially approaching other people more than is common, and a characteristic learning pattern with auditory short-term memory challenges.
- Persons with Fetal Alcohol Syndrome have trouble learning cause-and-effect relationships & get sensory overload more than typical.

Continued:

- Persons with Williams syndrome often have highly developed conversational skills & express sympathy and concern for other people, which is not always welcomed by strangers.
- Persons with Angelman syndrome have extremely high levels of motor activity & often have a happy facial expression, even during problem behavior, which can be misinterpreted.

Behavioral phenotypes are difficult to change.

"Guidelines for Positive Supports in DHS-Licensed Settings, A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans." Version 1.0. 18-19. Web April 2016. Minnesota Department of Human Services <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810C-ENG

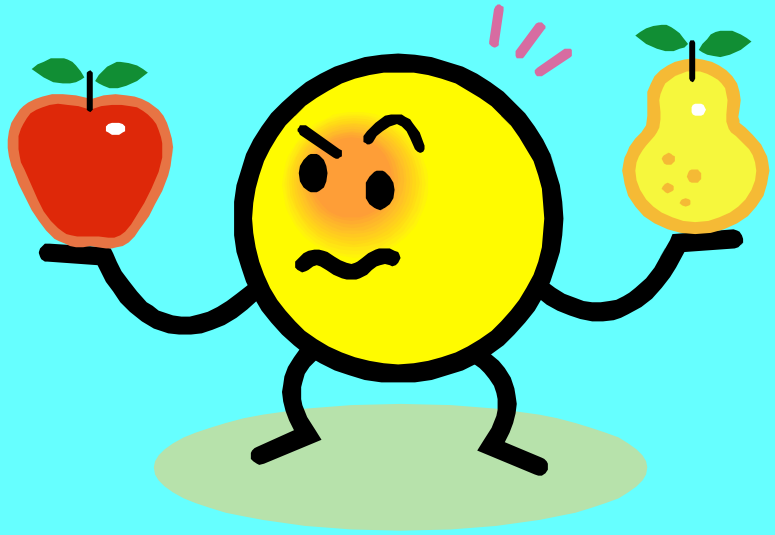
What is the person communicating?

7. Does this person have a history of traumatic experiences?

Trauma can result from being sent to your room too often, bullying or teasing from others, corporal punishment, abuse or neglect and many other factors. Trauma can cause emotional damage, hypervigilance, an inability to connect with people, and other psychiatric issues. The most well known result of traumatic experiences is Post Traumatic Stress Disorder (PTSD). PTSD can be difficult to identify without a thorough study.

Prevention is the Best Strategy

- Redirection Try to distract the person by getting them to focus on something else.
- Choices Avoid power struggles which will almost certainly result in a negative response or disruptive behavior. Instead, offer the person choices whenever possible.
- Wait Allow the person time to process what you've said. Because of their disability, it may take them several minutes for them to process and respond. Be patient!
- Provide treatment for medical problems



Prevention Techniques & Strategies

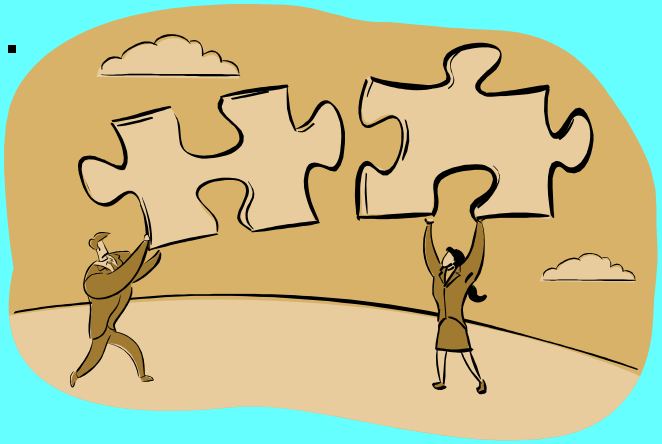
- Don't overwhelm the person It's nice that you want to want to help your co-workers, but resist the urge to step into a situation unless it's clear someone's going to get hurt. Individuals can easily feel like they're being "ganged up on" when a second staff steps in, which may result in the behavior getting worse.

- Be consistent People usually do better when they have predictable routines. All staff should try to respond to potentially challenging behaviors the same way.

- Be aware of your own bias You may find that you prefer to be around certain people and will try to avoid others. These feelings must not interfere with your provision of supports and services. You are a professional and, as such, you should not have "favorites" nor should you treat individuals differently based upon your feelings for them.

De-escalation Strategies

- Ask the person what's wrong and then try to solve the problem together.
- Distraction can work - Try to get the person focused on something else.

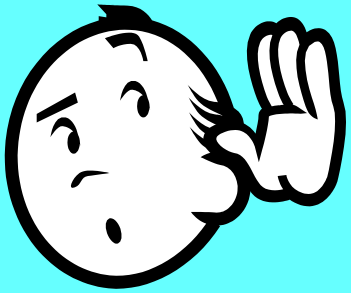


- Give the person time to calm before cueing.
- Give the person space.
- Offer alternatives and choices.
- Decrease excess sensory stimulation in the environment.

Additional De-escalation Strategies

- Try to move the person away from the others to prevent injuries and to give them a quiet place to calm down.
- If they won't move, have other near-by persons move away instead.

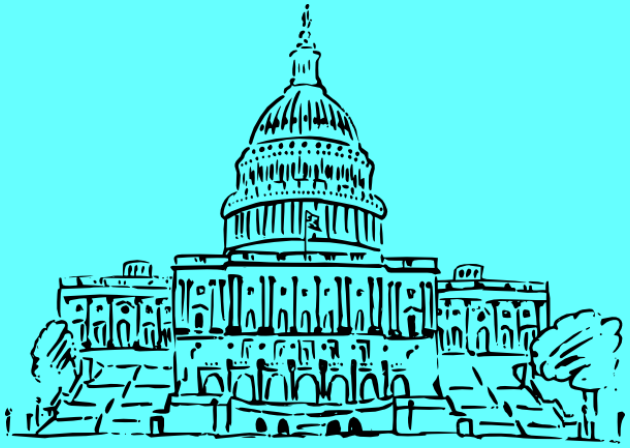
- Continue to try redirection. Allow them the space and time they need to self-regulate.



More Guidelines for Dealing with Negative Responses

"Behavior" is a form of communication!

- Take time to listen to what the behavior may be communicating:
  - Pain
  - Fear
  - Anger
  - Frustration
  - Boredom
  - Medication side effects, toxicity
  - Result of neurological issue (such as temporal lobe seizures.)
- Work with the person to remedy their concern.
- Do not discuss the individual's problem in front of others.
- Ask for help if you need it. If you see someone else dealing with an escalating situation, ask if you can help.
- Take responsibility! Learn about the individual's specific positive support strategies.



Part III

The Application of Statute and Rule Requirements related to:

- **Prohibited Procedures**
- **Restricted Procedures**
- **Permitted Actions and Procedures**

Categories Of Actions And Interventions Detailed In 245D.06:

1. **"Prohibited procedures"(245D.06, Subp. 5)** The license holder is prohibited from using these procedures.
2. **"Restricted procedures"(245D.06, Subp.6)** are allowed when the procedures are implemented in compliance with the standards governing their use and the following. Allowed but restricted procedures include:
   - permitted actions and procedures as identified above and on next slide per 245D.07;
   - procedures identified in a positive support transition plan subject to 245D.06, Subd. 8; or
   - emergency use of manual restraint subject to the requirements in 245D.061.
3. **"Permitted actions and procedures"(245D.06, Subd.7)** refer to the use of instructional techniques and intervention procedures identified on the following slide when used on an intermittent or continuous basis. When used on a continuous basis, it must be addressed in the a person's coordinated service and support plan addendum (CSSPA).

Use of chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience, is <u>prohibited</u> by PAI (and 245D.06, Subp. 5).

The Following Prohibited Procedures in 245D.06 are Also Prohibited per Rule 9544

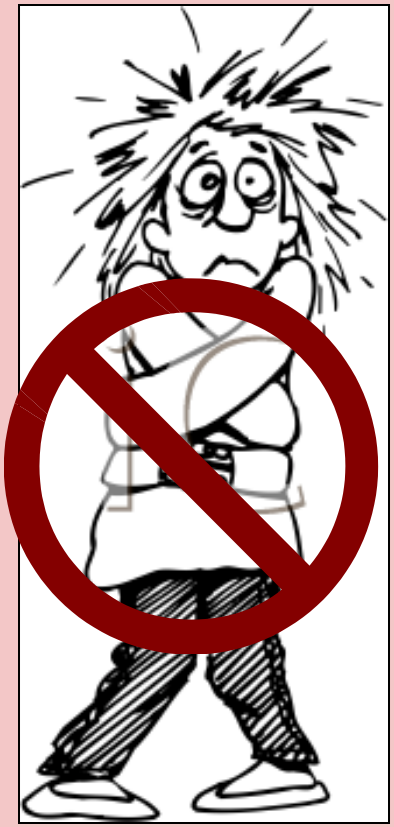
- Chemical restraint
- Mechanical restraint
- Manual restraint – programmatic *(as part of an on-going program)*
- Time out
- Seclusion
- Aversive and deprivation procedures

Prohibited Procedure: 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.

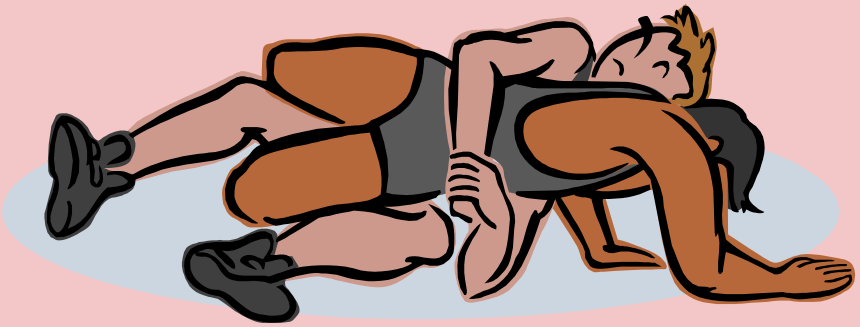
Prohibited Procedure: Mechanical Restraints

- "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:
  - 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
  - the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.



Prohibited Procedure: 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.



Prohibited Procedure: 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 chapter, "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.

Prohibited Procedure: Seclusion

“Seclusion” means 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 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.

Prohibited Procedures: Deprivation Procedures and Aversive Procedures

"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. Oftentimes 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.

"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.

Prohibited Procedures per 245D.06, Subp.6

You can NEVER implement a procedure in a manner that:

- constitutes abuse or neglect;
- violates a person's rights;
- restricts a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, necessary clothing, or any protection required by state licensing standards or federal regulations governing the program;
- denies the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;
- uses a procedure for the convenience of staff, as punishment, as a substitute for adequate staffing, or as a consequence if the person refuses to participate in the treatment or services provided by the program;
- uses prone restraint. For purposes of this section, "prone restraint" means use of manual restraint that places a person in a face-down position. Prone restraint does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, if the person is restored to a standing, sitting, or side-lying position as quickly as possible;
- applies back or chest pressure while a person is in a prone position, supine position, or side-lying position; or
- be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

Prohibited Procedures per 9544.0600

The following are prohibited from use as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience:

- Prone restraint;
- Faradic shock;
- Speaking to a person in a manner that ridicules, demeans, threatens or is abusive;
- Using physical intimidation/shows of force;
- Containing, restricting, isolating, secluding, or otherwise removing a person from normal activities when it is medically contraindicated or without monitoring the person;
- Denying or restricting a person's access to equipment and devices such as wheelchairs, walkers, hearing aids and communication boards that facilitates a 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;

- Using painful techniques;
- Hyperextending or twisting a person's body parts;
- Tripping or pushing a person;
- Using punishment of any kind;
- Requiring a person to assume and maintain a specified physical position or posture;
- Using forced exercise;

Prohibited Procedures per Rule 9544 - Continued

You Can NEVER Do These!

- Totally or partially restricting a person's senses;
- Presenting intense sounds, lights other sensory stimuli;
- Using a noxious smell, taste, substance or spray;
- depriving a person of or restricting access to normal goods and services, or requiring a person to earn normal goods and services;
- Using token or level programs that include response cost;
- Using a person receiving services to discipline another person receiving services;
- Using any action or procedure that is medically or psychologically contraindicated
- 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;
- interfering with a person's legal rights;
- using any other interventions or procedures that may constitute an aversive or deprivation procedure.

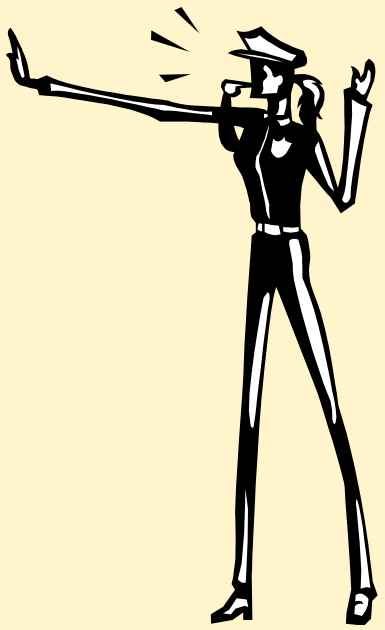
Staff having knowledge that a prohibited procedure has been used at PAI must report the occurrence verbally to their program director as soon as possible but no later than the close of the program day.

Next Steps:

- The program director must notify a PAI vice president upon receiving notification of the incident.
- The reporter will submit a PAI Incident Report detailing the circumstances of the use of a prohibited procedure.
- All applicable reports will be made to persons and agencies per licensing requirements.
- An internal review will be completed detailing recommendations for any disciplinary or training follow-up.

Restricted Procedures

- **Permitted procedures** used on a continuous basis must be in a person coordinated service & support plan addendum (CSSPA).
- **Positive support transition plans** for the emergency or programmatic use of restrictive procedures, or replace any existing plans (Rule 40 programs). These plans must:
  - Be developed on the forms and in the manner prescribed by the commissioner for a person 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.
  - Forwarded and approved by the commissioner or the designee.
  - Meet the required phasing out interval.
- **Emergency** use of manual restraint



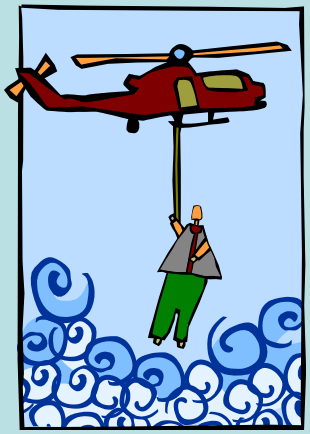
Restrictions on the use of procedures are governed by the requirements of 245D.06, subdivision 6, and 9544.0060

Permitted Actions and Procedures

Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:

- to calm or comfort a person by holding that person with no resistance from that person;
- to protect a person known to be at risk or injury due to frequent falls as a result of a medical condition;
- to 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;
- 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 staff; or
- 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.

Permitted Actions and Procedures - Continued



Restraint may be used as an intervention procedure to:

- allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional;
- 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
- 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 must comply with the restrictions identified in 245D.06, Subd. 6, part b, which lists the specific limitations pertaining to the implementation of any emergency use of manual restraint.

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.

Part IV

Conditions for the Emergency Use Of Manual Restraint at PAI

But Somebody Might Get Hurt!

What do you do if you couldn't prevent a behavior from happening?

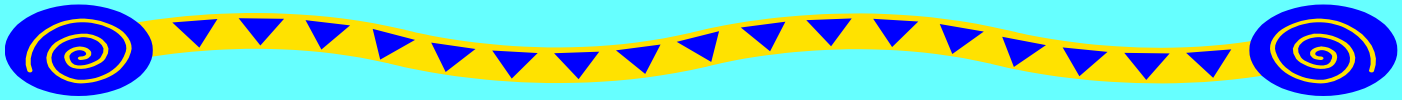
AND

You haven't been able to de-escalate the behavior?

AND

Someone is in imminent risk of physical harm?

Emergency Use of Manual Restraint (EUMR)



EUMR can only be used when:

- Other, less intrusive methods have failed **AND**
- Immediate intervention is needed to prevent the person or someone else from getting hurt **AND**
- PAI staff implementing the intervention have completed and are current in the prescribed training related to emergency use of manual restraint.

Emergency Use of Manual Restraint

Conditions for Use:

Emergency use of manual restraint must meet the following conditions:

- immediate intervention must be needed to protect the person or others from imminent risk of physical harm;
- the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety; and
- the manual restraint must end when the threat of harm ends.

The following conditions, on their own, are **not** conditions for emergency use of manual restraint:

- the person is engaging in property destruction that does not cause imminent risk of physical harm;
- the person is engaging in verbal aggression with staff or others; or
- the person is refusing to receive or participate in treatment or programming.

Prohibitions on the Emergency Use of Manual Restraint

Emergency use of manual restraint must not:

- Continue to be used after a person who has been subjected to three incidents of emergency use of manual restraint within 90 days or four incidents of emergency use of manual restraint within 180 days without the development of a Positive Support Transition Plan.
- Infringe on any of the specific prohibitions in 9544.0060, Subp.2 or 245D.06, Subd. 6:
  - be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

Emergency use of manual restraint must not:

- be implemented with an adult in a manner that constitutes abuse or neglect as defined in section 626.5572, subdivision 2 or 17;
- be implemented in a manner that violates a person's rights identified in section 245D.04;
- restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, necessary clothing, or any protection required by state licensing standards or federal regulations governing the program;
- deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;
- be used for the convenience of staff, as punishment, as a substitute for adequate staffing, or as a consequence if the person refuses to participate in the treatment or services provided by the program;

Emergency use of manual restraint must <u>not</u>:

- **<u>use prone restraint</u>**. “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.

- **<u>apply back or chest pressure</u>** while a person is in a prone, supine (meaning a face-up) or side-lying position.

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

Symptoms of Distress During an Emergency Use of Manual Restraint

- **Positional Asphyxia**
  - Asphyxia is a condition marked by the severely deficient supply of oxygen to the body that arises from being unable to breathe normally. During asphyxia, the lack of oxygen and the increase of carbon dioxide lead to unconsciousness and can lead to death as bodily organs and systems fail. Asphyxia can become life threatening in as little as a couple of minutes depending on the circumstances regarding physical exertion beforehand.
  - Positional Asphyxia occurs when breathing is restricted by the position a person's body is in, such as during a physical restraint when there is compression on the person's chest.
  - The following factors contribute to positional asphyxia deaths:
    - **Obesity** A large abdomen or "beer belly" means that when the person is prone the contents of the abdomen can be forced upward under the diaphragm restricting breathing.
    - **Psychosis** Stimulant drugs (amphetamines, Ritalin, etc.) can create an "excited delirium" in which the person is paranoid, agitated and potentially violent. The stimulation of the heart can produce cardiac rhythm disturbances which can be fatal. In this situation, any difficulty in breathing can result in sudden deterioration in the person's condition and death.
    - **Pre-existing physical conditions** Any condition that impairs breathing under normal circumstances will put a person at a higher risk when they are physically restrained. Examples are heart disease, asthma, emphysema, bronchitis and other chronic lung diseases.
    - **Pressure on the abdomen** Even a thin person will have difficulty breathing if there is pressure on the abdomen. The more staff that are holding a person down in a prone position, the greater the risk that there will be pressure on the person's abdomen, making it difficult to breathe.

Symptoms of Distress During an Emergency Use of Manual Restraint

- Symptoms of respiratory distress during a restraint include:
  - A person telling you he/she cannot breathe.
  - Gurgling/gasping sounds indicating blockage of the airway.
  - Lips, hands and face becoming dis-colored (blue) due to the lack of oxygen (cyanosis).
  - Increasing panic and/or prolonged resistance.
  - Sudden tranquility as airflow decreases. Example - An active, loud, threatening, violent and abusive person suddenly becoming quiet, tranquil and not moving.

The following actions will reduce the likelihood of a positional asphyxia death occurring:

- **The use of restraints can put the person in danger and staff should always attempt to use the least intrusive measure to prevent harm to the person or others.**
- **Identify persons at risk.** It is important to understand and know individuals' risk factor so to identify and reduce injury during potential situations.
- **<u>Never</u> use a prone restraint.**
- **Do not sit or lean on the abdomen <u>EVER</u>.**
- **Remain vigilant to the danger signs of asphyxia.**
- **Constantly monitor the person.** Continuously monitor a restrained person and, if possible, utilize another staff person, not involved in the restraint, to monitor the restrained person's condition.
- **Seek medical attention.**
  - Immediate medical attention should be obtained where there is any concern over the health and well-being of a person who has been restrained.

Potential Psychological and Physiological Impacts of Emergency Use of Manual Restraint on Staff

Potential Psychological Impact

Dehumanization: Perceiving those being restrained as inferior or less-than-human.

Dis-inhibition: Socio-cultural and situational pressures may cause a lessening of moral inhibitions related to insuring the rights, dignity, and respect afforded to those being restrained.

Institutionalization: The use of physical force becomes customary and acceptable as a standard of practice.

Fight-or-Flight Response: It is almost impossible to cultivate positive attitudes and beliefs when stress places us in a survival mode.

Potential Physiological Impact

Fight-or-Flight Response: Chemicals (adrenaline, noradrenaline and cortisol) are released into a person's bloodstream causing:

- Respiratory rate increases;
- Blood is shunted away from our digestive tract and directed into muscles and limbs;
- Pupils dilate and sight sharpens;
- Awareness intensifies and impulses quicken;
- Perception of pain diminishes;
- Rational thinking is impacted and well-thought out beliefs may be bypassed, activating an "attack" mode;
- Perception is altered and nearly everything is perceived as a potential threat;
- Thinking and reasoning are distorted;
- Fear is exaggerated; and/or
- Repetitive exposure to such response patterns can lead to disorders of the autonomic nervous system, causing headache, irritable bowel syndrome, high blood pressure, etc. It can also cause disorders of hormonal and immune systems, creating susceptibility to infection, chronic fatigue, depression, and auto-immune diseases like rheumatoid arthritis, lupus, and allergies.

Catecholamine Rush: The release of adrenal catecholamines that could sensitize the heart and produce rhythm disturbances

Potential Psychological and Physiological Impacts of Emergency Use of Manual Restraint on Recipient

Potential Psychological Impact

- Feelings of humiliation and loss of dignity;
- Diminished quality of life;
- Increased stress, confusion, fear
- Depression, withdrawal, isolation, desolation;
- Loss of hope and internal motivation;
- Anger, frustration, demoralization;
- Increased agitation, hostility, and aggression;
- Learned dependence;
- Sleep disturbances; and/or
- Diminished self-esteem.

?

Potential Psychological and Physiological Impacts of Emergency Use of Manual Restraint on Recipient

Potential Physiological Impact

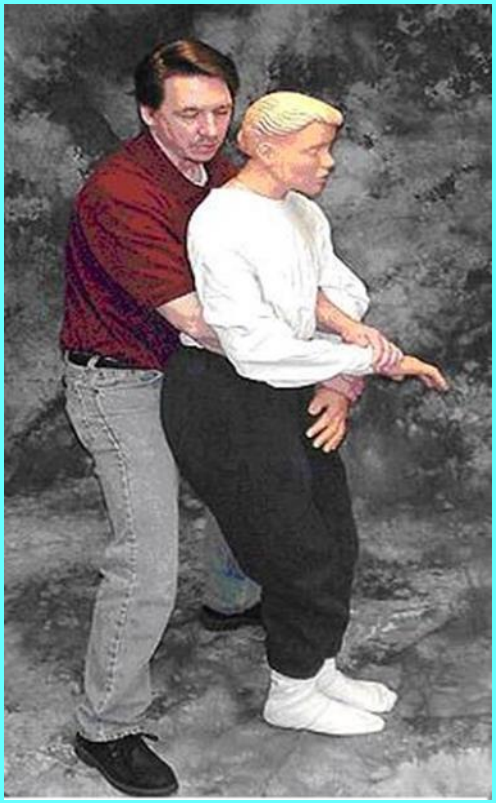
- Muscle stiffness and damage;
- Increased risk of respiratory infection;
- Physical discomfort and pain;
- Increased stress on the heart (Catecholamine Rush);
- Increased risk of death due to aspiration, strangulation or asphyxiation;
- Friction injuries on the skin;
- Serious injuries from falls;
- Increased morbidity and mortality;
- Increased risk of death from struggling to get free;
- Nerve injuries;
- Increased incontinence;
- Sleep disturbances;
- Restricted circulation;
- Fight-or-Flight Response

Excerpted from "Providing a Quality Life While Avoiding Restraint Usage," produced in 1999 by the Office of Quality Assurance.

PAI Permitted Restraint Holds for Use in an Emergency Use of Manual Restraint

Standing Cross Arm Hold

Seated Cross Arm Hold



Standing Cross Arm Hold

Techniques to Remember to Reduce Potential Injury:

- When standing, make sure your feet are positioned using a staggered stance, having one foot in front of the other. This offers a better position of power and affords you more stable footing. You will have better balance which will help decrease the chance of back strain should the person's position change unexpectedly.

- When using this intervention, you should insert your arms under the person's arms and grasp their forearms with your hands as shown. You should make sure that your hands are placed above the person's wrist joints and that only enough pressure is applied to secure the person's arms. You should make sure your face and head are to the side of the person's head to avoid injury from head tossing.

Seated Cross Arm Hold

Techniques to Remember to Reduce Potential Injury:

- This intervention typically occurs when a person drops to the floor during a standing cross arm hold. You should remain alert and be aware that the person in a standing hold could drop to the floor at any time. If possible, assist with lowering them to the floor. Continue to hold the person's arms, as in the standing hold, while positioning yourself behind them. Again, keep your head positioned to avoid being hit if they head butt.

Remember

Call 911 for law enforcement assistance if the allowed manual interventions cannot be safely implemented as required above or prove to be ineffective in achieving safety for the person and/or others.

Required Safety Monitoring Steps During the Emergency Use of Manual Restraint (per 245D.061, Subp. 4)

- A PAI staff will monitor the person's health and welfare during an emergency use of a manual restraint.
- When possible, the staff monitoring the procedure must not be the staff implementing the manual restraint.
- A monitoring form, approved by the commissioner, must be completed for each incident involving the emergency use of a manual restraint.

Practice Session:

During a July All Staff Meeting, Each Step To Be Done with a Partner

Standing Cross Arm Hold

1. Administering a standing cross arm hold.
2. Receiving a standing cross arm hold
3. Identifying thresholds for implementing and releasing the intervention.
4. Demonstration of what to do when the person has calmed:
   - Do not make immediate demands.
   - Allow them time to process.
   - Reinforce positive or neutral behavior.

Practice Session:

During a July All Staff Meeting, Each Step To Be Done with a Partner

Sitting Cross Arm Hold

1. Administering a sitting cross arm hold.
2. Receiving a sitting cross arm hold
3. Identifying thresholds for implementing and releasing the intervention.
4. Demonstration of what to do when the person has calmed:
   - Do not make immediate demands.
   - Allow them time to process.
   - Reinforce positive or neutral behavior.

Emergency Use of a Manual Restraint: What Must be Done

Staff must monitor a person's health and safety during an emergency use of manual restraint. The purpose of the monitoring is to ensure the following:

- only manual restraints allowed in this policy are implemented;
- manual restraints that have been determined to be contraindicated for a person are not implemented with that person;
- allowed manual restraints are implemented only by staff trained in their use;
- the restraint is being implemented properly as required; and
- 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.

When possible, a staff person who is not implementing the manual restraint must monitor the procedure. Best practice would have this be the program director or designated coordinator.

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

Reporting Emergency Use of Manual Restraint Incident (per 245D.061, Subp. 5)

Notify the PAI vice president as soon as possible after an emergency use of manual restraint.

Each single incident of emergency use of manual restraint must be reported separately. 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

(3) staff must immediately reimplement the restraint in order to maintain safety.

Within **24 hours** of an emergency use of manual restraint, the legal representative and the case manager must receive verbal notification of the occurrence. The PAI **Incident/Emergency Report** form must be completed.

Within **3 calendar days** after an emergency use of a manual restraint, the staff person who implemented the restraint must report details, in writing, on the **Initial Report of Emergency Use of Manual Restraint** form and submit it to their designated coordinator.

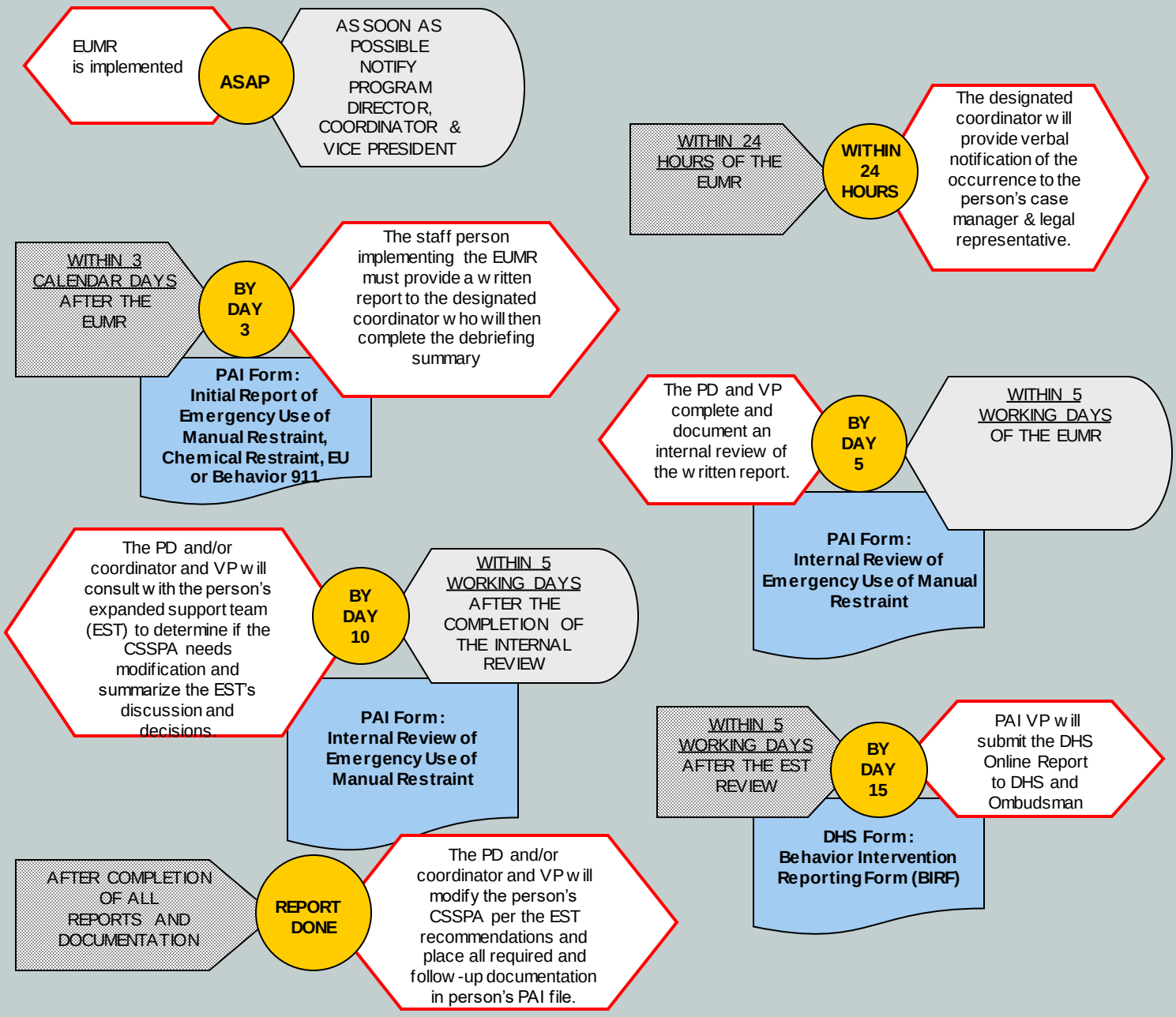
Reporting Emergency Use of Manual Restraint Incident (per 245D.061, Subp. 5)

Within **5 working** days after the date of the emergency use of a manual restraint, PAI's vice president and the PAI site's program director will complete the **Internal Review of Emergency Use of Restraint**.

Within **5 working** days after the completion of the internal review, the program director must consult with the expanded support team to discuss the incident and complete the summary section in the **Internal Review of Emergency Use of Restraint.**

Within **5 working days** after the completion of the expanded support team review, the PAI site program director, under the direction of the vice president, will finalize and submit the required report information to the DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities (per 245.94, Subd. 2a) using the online reporting tool. **https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG**

All required emergency use of manual restraint documentation and other related required documents must be maintained in the person's permanent record for at least five years.


EUMR is implemented
ASAP
AS SOON AS POSSIBLE NOTIFY PROGRAM DIRECTOR, COORDINATOR & VICE PRESIDENT
WITHIN 24 HOURS OF THE EUMR
WITHIN 24 HOURS
The designated coordinator will provide verbal notification of the occurrence to the person's case manager & legal representative.
WITHIN 3 CALENDAR DAYS AFTER THE EUMR
BY DAY 3
The staff person implementing the EUMR must provide a written report to the designated coordinator who will then complete the debriefing summary
PAI Form: Initial Report of Emergency Use of Manual Restraint, Chemical Restraint, EU or Behavior 911
The PD and VP complete and document an internal review of the written report.
BY DAY 5
WITHIN 5 WORKING DAYS OF THE EUMR
PAI Form: Internal Review of Emergency Use of Manual Restraint
The PD and/or coordinator and VP will consult with the person's expanded support team (EST) to determine if the CSSPA needs modification and summarize the EST's discussion and decisions.
BY DAY 10
WITHIN 5 WORKING DAYS AFTER THE COMPLETION OF THE INTERNAL REVIEW
PAI Form: Internal Review of Emergency Use of Manual Restraint
WITHIN 5 WORKING DAYS AFTER THE EST REVIEW
BY DAY 15
PAI VP will submit the DHS Online Report to DHS and Ombudsman
DHS Form: Behavior Intervention Reporting Form (BIRF)
AFTER COMPLETION OF ALL REPORTS AND DOCUMENTATION
REPORT DONE
The PD and/or coordinator and VP will modify the person's CSSPA per the EST recommendations and place all required and follow-up documentation in person's PAI file.