



POLICY AND PROCEDURE  
**EMERGENCY USE OF  
MANUAL RESTRAINT**

Annual July Training

1<sup>st</sup> edition July 2023

This training to be delivered in conjunction with STAR LMS PSR Core Breakout De-escalation Techniques  
& a on-site demonstration of competency

PAI recognizes the importance of having qualified, knowledgeable staff that are competently trained to uphold the rights of persons served and to protect persons' health & safety.

All PAI staff will receive orientation and annual training according to MN Statutes, section 245D.09, subdivisions 4, 4a, and 5.

Within 60 calendar days of hire, and annually thereafter, the company provides orientation and training on:

The safe, correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 and what constitutes the use of restraints, time out, and seclusion, including chemical restraint;

Staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, MN Rules, part 9544.0060, why such procedures are not effective and why such procedures are not safe.

Before staff may implement an emergency use of manual restraint, and in addition to the training on this policy & procedure staff must receive training that incorporates the following topics:

Alternatives to manual restraint, the communicative intent of behaviors & relationship building

De-escalation methods, positive support strategies, and how to avoid power struggles

A simulated experiences of administering & receiving restraint procedures allowed by PAI

How to properly identify thresholds for implementing/ceasing restrictive procedures

How to recognize, monitor, and respond to the person's physical signs of distress.

The impact on the person & the staff when restrictive procedures are used



# **POSITIVE SUPPORT STRATEGIES**

Staff 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 a situation & are options that could be implemented by staff. *This is not a fully inclusive list of options:*

- A calm discussion between the person served and direct support staff regarding the situation, the person's feelings, their responses, and alternative methods to handling the situation, etc.
- A staff suggesting or recommending that the person participate in an activity they enjoy as a way to self-calm.
- A staff to suggest or remind that the person served has options that they may choose, such as to spend time alone, when safety permits, as a means to self-calm.
- Implement any of the individualized strategies that have been written into the person's Support Plan and/or Support Plan Addendum, or Positive Support Transition Plan.
- The implementation of instructional techniques and intervention procedures that are listed as "Permitted actions and procedures".
- A combination of any of the above.

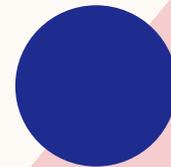
# BEHAVIOR AS COMMUNICATION

*Ask yourself....*

Is the interfering behavior a symptom of a medical disorder?

*Here is an example:*

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



# BEHAVIOR AS COMMUNICATION

*Ask yourself....*

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

*Here are some examples:*

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Biting side of hand/whole mouth	<ul style="list-style-type: none"><li>• Sinus problems</li><li>• Ears/Eustachian tubes</li><li>• Eruption of wisdom teeth</li><li>• Dental problems</li><li>• Paresthesia/painful sensations (e.g., pins &amp; needles) in hand</li></ul>
Biting thumbs/objects with front teeth	<ul style="list-style-type: none"><li>• Sinus problems</li><li>• Ears/Eustachian tubes</li></ul>
Biting with back teeth	<ul style="list-style-type: none"><li>• Dental</li><li>• Otitis (ear)</li></ul>
Fist jammed in mouth/down throat	<ul style="list-style-type: none"><li>• Gastroesophageal reflux</li><li>• Eruption of teeth</li><li>• Asthma</li><li>• Rumination</li><li>• Nausea</li></ul>

# More examples:

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Intense rocking/preoccupied look	<ul style="list-style-type: none"><li>• Visceral pain</li><li>• Headaches</li><li>• Depression</li><li>• Dissociative Disorder</li></ul>
Odd un-pleasant masturbation	<ul style="list-style-type: none"><li>• Prostatitis</li><li>• Urinary tract infection</li><li>• Candida vagina</li><li>• Pinworms</li><li>• Repetition phenomena, PTSD</li></ul>
Pica – ingesting inedibles	<ul style="list-style-type: none"><li>• General: OCD, hypothalamic problems, history of under-stimulating environments</li><li>• Cigarette butts: nicotine addiction, generalized anxiety disorder</li><li>• Glass: suicidality</li><li>• Paint chips: lead intoxication</li><li>• Sticks, rocks, other jagged objects: endogenous opiate addiction</li><li>• Dirt: iron or other deficiency state</li><li>• Feces: PTSD, psychosis</li></ul>
Scratching/hugging chest	<ul style="list-style-type: none"><li>• Asthma</li><li>• Pneumonia</li><li>• Gastroesophageal reflux</li><li>• Costochondritis/"slipped rib syndrome"</li><li>• Angina</li></ul>
Scratching stomach	<ul style="list-style-type: none"><li>• Gastritis</li><li>• Ulcer</li><li>• Pancreatitis (also pulling at back)</li><li>• Porphyria (bile pigment that causes, among other things, skin disorders)</li><li>• Gall bladder disease</li></ul>

# More examples:

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Self-restraint/binding	<ul style="list-style-type: none"><li>• Pain</li><li>• Tic or other movement disorder</li><li>• Seizures</li><li>• Severe sensory integration deficits</li><li>• PTSD</li><li>• Paresthesia</li></ul>
Stretched forward	<ul style="list-style-type: none"><li>• Gastroesophageal reflux</li><li>• Hip/back pain</li><li>• Back pain</li></ul>
Sudden sitting down	<ul style="list-style-type: none"><li>• Atlantoaxial dislocation (dislocation between the vertebrae in the neck)</li><li>• Cardiac problems</li><li>• Seizures</li><li>• Syncope/orthostasis (fainting or light-headedness caused by medications or other physical conditions)</li><li>• Vertigo</li><li>• Otitis (thrown off balance by problems in the ear)</li></ul>
Uneven seat	<ul style="list-style-type: none"><li>• Hip pain</li><li>• Genital discomfort</li><li>• Rectal discomfort</li></ul>
Walking on toes	<ul style="list-style-type: none"><li>• Arthritis in ankles, feet, hips or knees</li><li>• Tight heel cords</li></ul>
Waving fingers in front of the eyes	<ul style="list-style-type: none"><li>• Migraine</li><li>• Cataract</li><li>• Seizure</li><li>• Rubbing caused by blepharitis (inflammation of the eyelid) or corneal abrasion</li></ul>

# More examples:

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Waving head side to side	<ul style="list-style-type: none"><li>• Declining peripheral vision or</li><li>• Reliance on peripheral vision</li></ul>
Whipping head forward	<ul style="list-style-type: none"><li>• Atlantoaxial dislocation (dislocation between the vertebrae in the neck)</li><li>• Pain in hands/arthritis</li></ul>
Won't sit	<ul style="list-style-type: none"><li>• Akathisia (inner feeling of restlessness)</li><li>• Back pain</li><li>• Rectal problem</li><li>• Anxiety disorder</li></ul>
General Scratching	<ul style="list-style-type: none"><li>• Eczema</li><li>• Drug effects</li><li>• Liver/renal disorders</li><li>• Scabies</li><li>• Bed bugs</li></ul>
Head Banging	<ul style="list-style-type: none"><li>• Pain</li><li>• Depression</li><li>• Migraine</li><li>• Dental</li><li>• Seizure</li><li>• Otitis (ear ache)</li><li>• Mastoiditis (inflammation of bone behind the ear)</li><li>• Sinus problems</li><li>• Tinea capitis (fungal infection in the head)</li><li>• Hearing internal voices</li></ul>

# BEHAVIOR AS COMMUNICATION

*Ask yourself....*

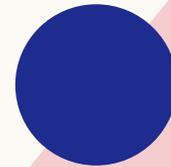
Is the interfering behavior influenced by medications they are taking?

*Here is an example:*

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

Anticholinergic medications treat Parkinson's disease, chronic obstructive pulmonary disease (COPD), and overactive bladder.

Other medications, such as first-generation antihistamines and tricyclic antidepressants, have anticholinergic side effects that aren't related to the condition they treat.



# BEHAVIOR AS COMMUNICATION

*Ask yourself....*

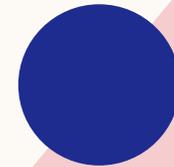
Is the interfering behavior part of a cluster or chain of related behaviors?

*Here is an example:*

Everyday when it's time to get on the bus a person served has some type of "behavior"; they may refuse to get up, pretend to be sick, run away or attack others.

These "behaviors" may all be related to getting on the bus and one intervention may solve many challenges.

If not related, 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.



# BEHAVIOR AS COMMUNICATION

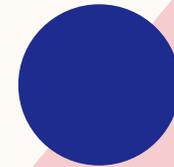
*Ask yourself....*

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

*Here is an example:*

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 themselves to make the demand go away.

Similarly, a person who hasn't developed coping skills may have difficulty handling stressful situations.



# BEHAVIOR AS COMMUNICATION

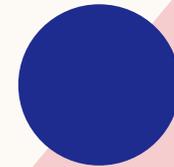
*Ask yourself....*

Does this person have a history of traumatic experiences?

*Here is an example:*

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).



# BEHAVIOR AS COMMUNICATION

*Ask yourself....*

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.

*Here is an example:*

Persons with Down syndrome have a characteristic personality of 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.

*Here is an example:*

Persons with Williams syndrome often have highly developed conversational skills & express sympathy & concern for others, 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.*

# *“Behavior” is a form of communication!*

Take responsibility! Learn about the individual’s specific positive support strategies.

Take time to listen to what the behavior may be communicating:

Pain, Fear, Anger, Frustration,  
Boredom, Medication side effects,  
Toxicity, Neurological issue etc.

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.



# PERMITTED ACTIONS & PROCEDURES

**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 *Support Plan*.

# PERMITTED ACTIONS

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:

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

2. 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.
- Position a person with physical disabilities in a manner specified in their Support Plan Addendum.

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

**Can never 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 treatment/services provided by PAI

# PROHIBITED PROCEDURES

**THE COMPANY AND ITS STAFF ARE PROHIBITED FROM USING THE FOLLOWING:**

## CHEMICAL RESTRAINTS

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.

## 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.

## 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.

## 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.

# PROHIBITED PROCEDURES

**THE COMPANY AND ITS STAFF ARE PROHIBITED FROM USING THE FOLLOWING:**

## SECLUSION

Seclusion means involuntarily removing or separating a person from an area, activity, situation, or social contact with others and 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 block or prevent the person's return.

## AVERSIVE PROCEDURES

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.

## DEPRIVATION 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.

## USES PRONE RESTRAINT

Prone restraint means use of manual restraint that places a person in a face-down position.  
  
Never apply back or chest pressure while a person is in a prone position, supine position, or side-lying position

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

# PROHIBITED PROCEDURES

YOU CAN **NEVER** IMPLEMENT A PROCEDURE IN A MANNER THAT CONSTITUTES ABUSE,

NEGLECT, OR VIOLATES A PERSON'S RIGHTS

*Examples include:*

Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive

Physical intimidation or a show of force

Painful techniques, including intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization, and degradation

Hyperextending or twisting a person's body parts

Tripping or pushing a person

Requiring a person to assume and maintain a specified physical position or posture

Forced exercise

Totally or partially restricting a person's senses

Presenting intense sounds, lights, or other sensory stimuli

Noxious smell, taste, substance, or spray, including water mist

Token reinforcement programs or level programs that include a response cost or negative punishment component

Using a person receiving services to discipline another person receiving services

Using an action or procedure which 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

# PROHIBITED PROCEDURES

YOU CAN **NEVER** IMPLEMENT A PROCEDURE IN A MANNER THAT CONSTITUTES ABUSE,  
NEGLECT, OR VIOLATES A PERSON'S RIGHTS

## *Examples include:*

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.*

Faradic shock

Restricting 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.

Denying the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin.

# EMERGENCY USE OF MANUAL RESTRAINT (EUMR)

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:

All other least restrictive intervention methods have failed.

Immediate intervention needed to protect the person or others from imminent risk of physical harm

Staff implementing the manual restraint has been trained.

Restraint used is the least restrictive needed to eliminate the immediate risk of harm & effectively achieve safety.

The manual restraint ends when the threat of harm ends.

# THE FOLLOWING CONDITIONS, ON THEIR OWN, ARE NOT CONDITIONS FOR EMERGENCY USE OF MANUAL RESTRAINT:

Engaging in property destruction that does not cause imminent risk of physical harm

Engaging in verbal aggression with staff

Engaging in verbal aggression with others

Refusing to receive or participate in treatment.

Refusing to receive or participate in programming.

The company allows certain types of manual restraints which may be used by staff on an emergency basis.

# **ALLOWED MANUAL RESTRAINTS:**

## **PHYSICAL ESCORT/WALKING:**

- Stage 1
- Stage 2

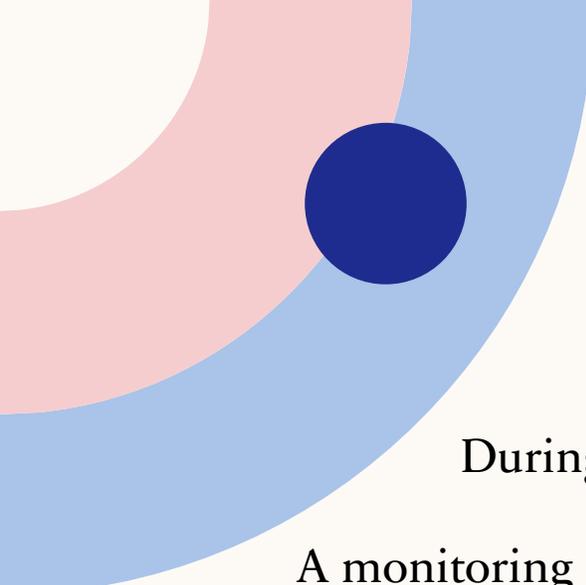
## **ARM RESTRAINT/ONE STAFF PERSON STANDING:**

- 1 arm
- 2 arm

## **ARM RESTRAINT/ONE STAFF PERSON SITTING:**

- 1 arm
- 2 arm

Detailed instructions on the safe and correct implementation of these procedures are included at the end of this policy.



# MONITORING & REPORTING OF EUMR

During an emergency use of manual restraint, the company will monitor a person's health and safety.

A monitoring form will be completed by the staff person for each incident of EUMR.

This report is to ensure:

1. Only manual restraints allowed according to this policy are implemented.
2. 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.

# MONITORING & REPORTING OF EUMR

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.

An incident is when the following conditions have been met:

1. After implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety.
2. Upon the attempt to release the restraint, the person's behavior immediately re-escalates and staff must immediately re-implement the restraint in order to maintain safety.

**Each single incident must be monitored and reported separately.**

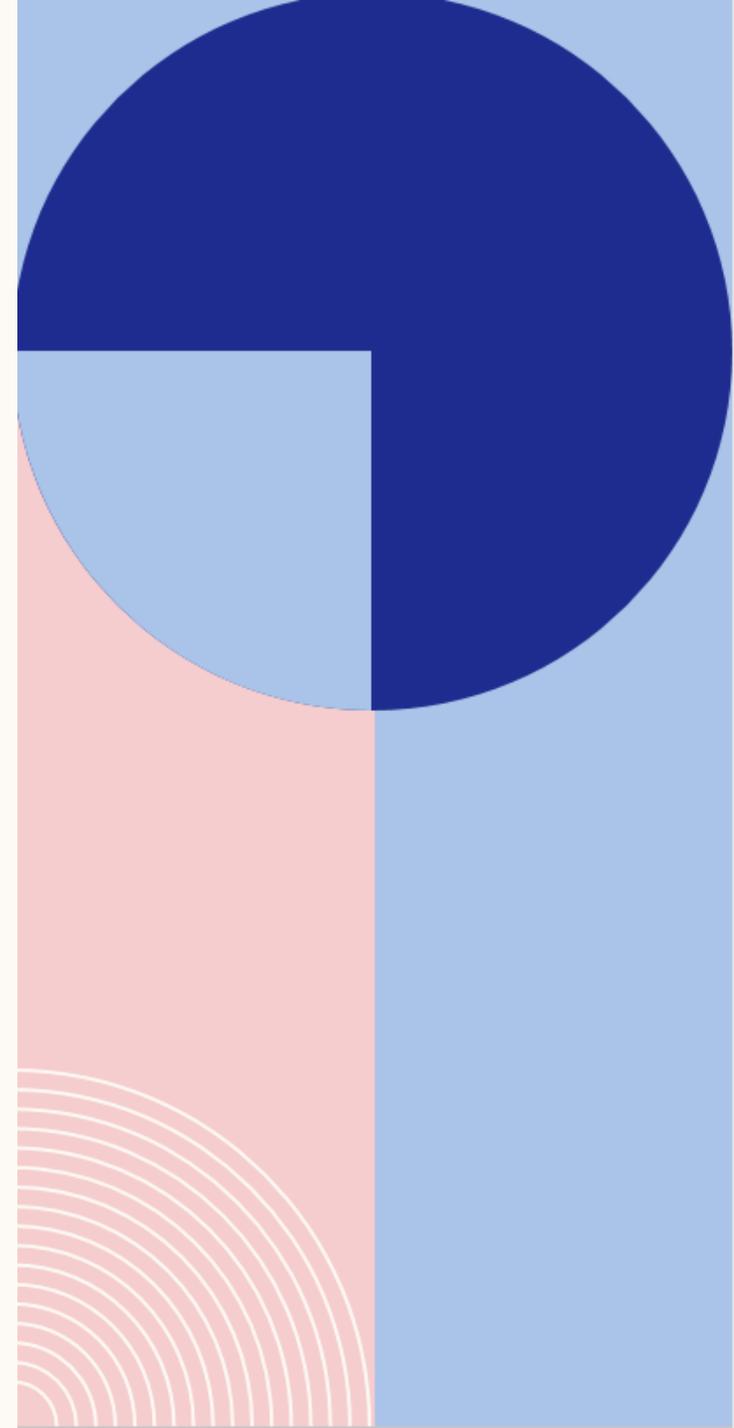
**Within 24 hours**, the company will make a verbal report regarding the incident to the legal representative or designated emergency contact and case manager.

If other persons served were involved in the incident, the company will not disclose any personally identifiable information about any other person when making the report unless the company has the consent of the person.

*Staff monitoring the manual restraint procedure will not be the staff implementing the procedure, when possible.*

**Within three (3) calendar days**, the staff who implemented the 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 restraint.
2. A description of the physical and social environment, including who was present before and during the incident leading up to the 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.



## EMERGENCY USE OF MANUAL RESTRAINT INCIDENT REPORT

### Behavior intervention information

\*This section to be completed within 3 calendar days by staff who implemented the emergency use of manual restraint (EUMR).

Name of person served: \_\_\_\_\_ Date of the EUMR: \_\_\_\_\_ Time of use: \_\_\_\_\_

Name and title of staff completing this section: \_\_\_\_\_

Date of completion: \_\_\_\_\_

Location type: \_\_\_\_\_

Location address: \_\_\_\_\_

Staff and persons served who were involved in the incident leading up to the emergency use of manual restraint:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Title: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Title: \_\_\_\_\_

Staff (if available) who monitored the person's health and welfare during the EUMR:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Title: \_\_\_\_\_

\*If an additional staff was not available to monitor, the staff conducting the EUMR is responsible for monitoring during the EUMR.

The behavior the person displayed that required the use of an intervention included – choose all that apply:

- Physical aggression/physical assault  Self-injury/self-harm  
 Self-endangerment/risk to personal safety  Property destruction/damage that could harm the person/others

Describe the behavior intervention used and the resulting outcome: \_\_\_\_\_

Length of use: \_\_\_\_\_

Describe the physical and social environment, including who was present *before* and *during* the incident leading up to the emergency use of manual restraint: \_\_\_\_\_

Describe what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented: \_\_\_\_\_

Identify when, how, and how long the alternative measures were attempted before the manual restraint was implemented: \_\_\_\_\_

Time when de-escalation occurred: \_\_\_\_\_

Length of time involved in de-escalation efforts: \_\_\_\_\_ hours \_\_\_\_\_ minutes

Describe 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: \_\_\_\_\_

Was there any injury to the person who was restrained or other persons involved in the incident, including staff, *before* or *as a result* of the use of intervention?  Yes  No

If yes, indicate who was injured and what their injury(ies) were: \_\_\_\_\_

If yes, indicate what care was provided for the injured person(s): \_\_\_\_\_

Following the incident, was there 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?

Staff:  Yes  No Person served:  Yes  No Other people:  Yes  No

If yes, describe the outcome of the debriefing: \_\_\_\_\_

If no, indicate whether a debriefing is planned: \_\_\_\_\_

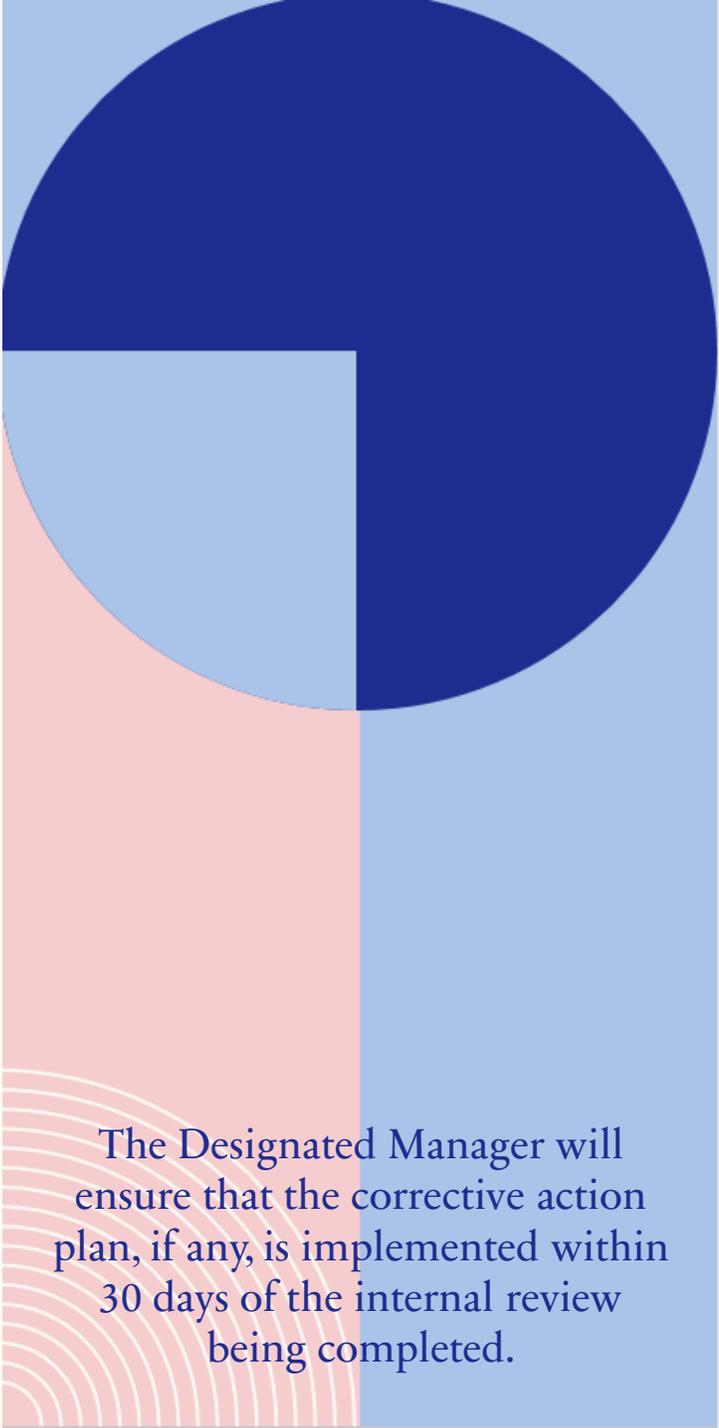
Name of staff who implemented the EUMR \_\_\_\_\_

Date \_\_\_\_\_

**Within five (5) working days**, the Designated Manager will complete & document an internal review of each report of emergency use of manual restraint. The internal review will include an evaluation of whether:

1. The person's served service and support strategies developed according to MN Statutes, sections 245D.07 and 245D.071 need to be revised.
2. Related policies and procedures were followed.
3. The policies and procedures were adequate.
4. There is a need for additional staff training.
5. The reported event is similar to past events with the persons, staff, or the services involved.
6. There is a need for corrective action by the company to protect the health and safety of the person(s) served.

Based upon the results of the internal review, the company will develop, document, and implement a corrective action plan for the program designed to correct current lapses & prevent future lapses in performance by the individuals or the company, if any.

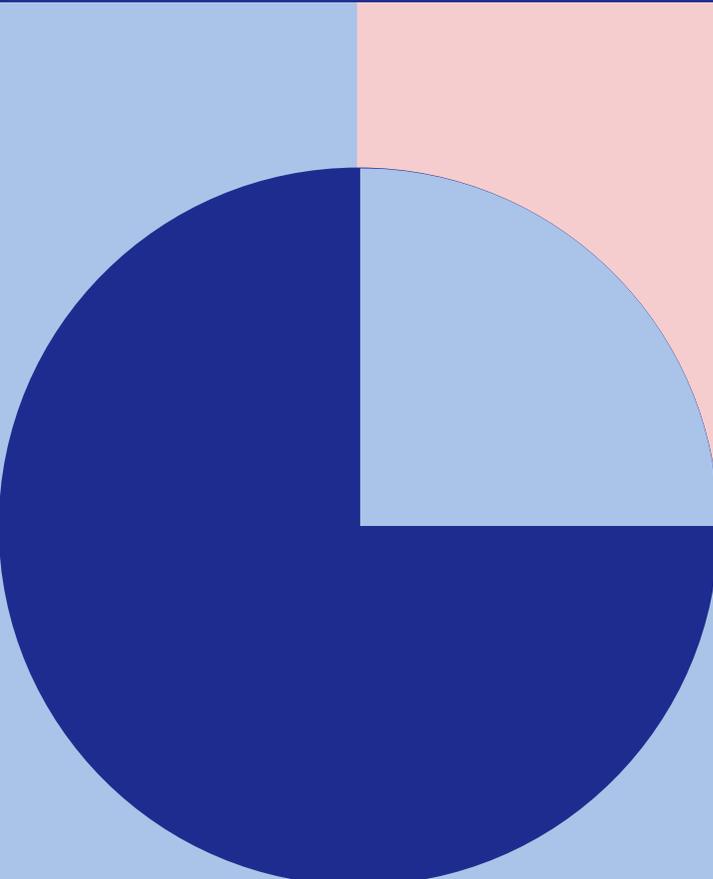


The Designated Manager will ensure that the corrective action plan, if any, is implemented within 30 days of the internal review being completed.



**Within five (5) working days**, 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 Support Plan Addendum needs to be revised to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.



**Within five (5) working days**, of the expanded support team review, the Designated Coordinator and/or Designated Manager will submit 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.

\*using the DHS online Behavioral Intervention Reporting Form (DHS-5148-ENG-1)

# ALLOWED MANUAL RESTRAINTS:

Detailed instructions on the safe and correct implementation of these 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.

If a person served has escalating behaviors and it is necessary to move the person, staff may follow stages 1 & 2 of physical escort/walking.

## PHYSICAL ESCORT/WALKING:

### Stage 1

Staff person will walk by the side of the person while remaining slightly behind the person.

Staff will place their hand that is closest to the person, on the person's forearm, just below the elbow while applying firm, but gentle pressure.

While walking with the person, staff will remain near to the person so that the placement of the hand on the person's forearm is effective.

# ALLOWED MANUAL RESTRAINTS:

The least restrictive manual restraint will be used to effectively handle the situation.

## PHYSICAL ESCORT/WALKING:

### Stage 2

If stage 1 is not effective, staff may use both of their hands to move the person while walking.

Staff will move their hand currently on the person's forearm to the person's small of their back and apply firm, but gentle pressure.

Staff's other arm, that is farthest away from the person, will reach across and be placed on the person's forearm, below the elbow, while applying firm, but gentle pressure.

In this position, staff will remain near to the person while walking with them to another area.

# ALLOWED MANUAL RESTRAINTS:

If a person served has escalating behaviors that can be managed using a one arm restraint, staff will attempt to do so prior to using the two arm restraint.

A standing restraint will be attempted first; however, if the person needs to sit, staff may use the arm restraint/one staff person sitting procedure.

Staff may use physical escort/walking, stage 2 to move into the 1 arm restraint or it may be used separately.

## ARM RESTRAINT ONE STAFF PERSON STANDING:

### **1 arm**

Staff will direct one arm of the person served forward to cross in front of the person's body by applying slight pressure above or below their elbow. The same side arm will be used by staff and the person (i.e. staff's right arm will direct the right arm of the person forward).

With their other arm, farthest away from the person, staff will lightly grip the person's crossed arm, slightly above the wrist, holding the arm in a crossed position.

Staff will then slide their free arm between the person's arm and their waist, to grip the person's forearm ensuring that their palms are facing down.

# ALLOWED MANUAL RESTRAINTS:

Detailed instructions on the safe and correct implementation of these procedures.

## ARM RESTRAINT ONE STAFF PERSON STANDING:

### 2 arm

Staff will direct one arm of the person served forward to cross in front of the person's body by applying slight pressure above or below their elbow. The same side arm will be used by staff and the person (i.e. staff's right arm will direct the right arm of the person forward).

With their other arm, farthest away from the person, staff will lightly grip the person's crossed arm, slightly above the wrist, holding the arm in a crossed position.

Staff will then slide their free arm between the person's arm and their waist, to grip the person's forearm. Ensuring that their palms are facing down.

If the person continued to escalate in behaviors and it is necessary to restrain both arms, staff will release their arm that is gripping the person's arm above the wrist.

Staff will quickly bring their arm up and around to "pin" the person's free arm against their side.

Staff will then re-grip the arm above the wrist that is crossed in front of the person so that one arm is crossed in front of the person and the other pressed against the person's side.

# ALLOWED MANUAL RESTRAINTS:

Using the procedures as stated in the arm restraint one staff person standing – 1 arm and 2 arm, Staff may transition from a standing to a sitting position if necessary.

## ARM RESTRAINT ONE STAFF PERSON SITTING:

### **1 arm and 2 arm:**

While restraining the person's arm(s), staff will verbally notify the person of what they are doing.

Staff will slowly back up and lower the person to the floor.

Staff may be in a sitting or kneeling position behind the person.

Should the person attempt to hit staff with their head or aggressively rock back and forth, staff will pull slightly back while maintaining their restraint.

If possible, staff will brace their shoulder against the person's shoulder or duck their head to avoid being hit.



Other ways to watch video:  
Navigate to <https://youtu.be/LvsbsaaOZLU> in browser  
or Launch LMS Training

**THANK YOU**

The background features a large white circle on the left and a large pink circle on the right, both overlapping a dark blue background. The pink circle contains several thin, white, concentric circular lines.