UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, *et al.*,

Plaintiffs,

v.

Minnesota Department of Human Services, an agency of the State of Minnesota, *et al.*,

Defendants.

Civil No. 09-1775 (DWF/FLN)

REPORT TO THE COURT:

RECOMMENDED REVISION TO MSHS-CAMBRIDGE RESTRAINT POLICY

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December 6, 2013

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I. Purpose

This report is to recommend to the Court that an up-to-date Restraint Policy replace Attachment A to the Settlement Agreement.[1]

To avoid confusion and to achieve clarity on Defendants' obligations, it is important that a Revised Restraint Policy receive the imprimatur of the Court. That Cambridge is to be succeeded by small community facilities – at which mechanical restraint will be prohibited -- reinforces the need for formalizing any policy revisions.

As adopted December 5, 2011, the Jensen Settlement Agreement forbids the use of all restraints at MSHS-Cambridge with an emergency exception permitting manual (*i.e.*, personal physical contact) and two types of mechanical restraint (*i.e.*,Velcro soft cuffs and fabric ankle straps). Implementation of the policy is at Attachment A to the settlement agreement. Since that time, there have been other versions with almost identical content, but they have not been approved by the Court.[2] Collectively, they are referred to here as the "MSHS-Cambridge Restraint Policy" or "Restraint Policy."

The Department of Human Services responded positively to the draft of this report, acknowledging the need for revisions and providing proposed new

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[1] A draft of this report was provided to the parties more than ten days prior to submission of this final report. Plaintiff Class Counsel concurred with the draft report recommendations. Copies of the parties' responses are attached as Exhibits A and B to this report. The latest – and today accepted – version of the policy is within Exhibit A, and marked, "Effective December 4, 2013."

[2] The title of the Restraint Policy has remained the same: "Therapeutic Interventions and Emergency Use of Personal Safety Techniques."

The policy/procedure has been re-issued twice since the approval of the Settlement Agreement.

- November 1, 2010. Procedure #3503. Effective December 2010. This is Attachment A to the Settlement Agreement (Dkt. 104-1, filed June 23, 2011).
- March 7, 2013. Procedure #15868. Effective March 15, 2013.
- November 8, 2013. Procedure #15868. Effective November 12, 2013.

documents which meet the concerns of the Court Monitor. Plaintiffs also responded positively.[3]

The Court Monitor appreciates the parties' cooperation to "close the loop" on this important matter.

II. The 2012 Stipulation to Revise the Restraint Policy Was Not Adopted

The Settlement Agreement's Attachment A sets forth the prohibition on all restraints at MSHS-Cambridge, except for emergency use of manual restraint and "Velcro soft cuffs and fabric ankle straps."

To their credit, the parties agreed during in October, 2012 to eliminate the Velcro soft cuffs and fabric ankle straps exception, thus to establish Cambridge as a facility entirely free from use of mechanical restraints.

This significant change, however, has not been adopted by the Court. Court Monitor, *Third Report to the Court* (Nov. 16, 2012, Dkt. 183) (recommending revision to Attachment A). The parties' Stipulation on the Monitor role referenced that change but they have not followed up after the Court's order on the Monitor role.[4]

III. DHS' November 2013 Policy Needs Revision

On November 12, 2013, just after the Restraint Policy was questioned by the Court Monitor's consultants, the *Jensen* Compliance Officer provided a policy "updated" from a March 7, 2013 policy. The new policy was "effective" November 12, 2013.[5] Neither the March 7, 2013 nor the November 12, 2013 revision to Attachment A has been presented to the Court for approval.

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[3] Email to Court Monitor from Christina Baltes, December 6, 2013, with attachments. Plaintiff Class Counsel concurred with the draft report recommendations. Copies of the parties' responses are attached as Exhibits A and B to this report.

[4] The parties' stipulation on the monitor role included a provision on Attachment A, but the stipulation was not addressed by the Court. The Stipulation included a one-sentence paragraph referencing an Attachment C on "Implementation of Controlled Procedures" to be incorporated into the Settlement Agreement. Stipulation at ¶VI.A. (Feb. 4, 2013). The Court noted the stipulation but did not adopt it. Order of March 19, 2013.

[5] The Monitor has been finalizing the Settlement Agreement/Cambridge Closure implementation plan under the Order of August 28, 2013. The Court

The cover memorandum with the November 12, 2013 revision stated that the "changes made" were to delete the single sentence approving "Velcro soft cuffs and fabric ankle straps."[6] However, that revision has some changes beyond that single deletion. The November 12, 2013 Restraint Policy is Exhibit C to this Report.

The table below shows the differences between the new and original documents.

- For differences which are minor and appropriate, the table cells are are highlighted in green.
- Language which is problematic, is highlighted in red.

DIFFERENCES BETWEEN THE POLICIES

New Attachment A (Nov. 12, 2013)	Original Attachment A (November 1, 2010)
1. Throughout: Uses term "Program Plan"	1. Throughout: Uses term "Treatment Plan"
2. Defines a "Designated Coordinator" who produces the client's IPP "under the supervision of the *Mental Health Professional."* (emphasis added)	2. No definition of a "Designated Coordinator." The IDT identifies as a Team member a lower case "designated coordinator" as someone with experience re "a behavior intervention program," and not as someone who is a "Mental Health Professional."
2. Throughout: Uses term "Interdisciplinary Team."	2. Throughout: Uses term: "Expanded Interdisciplinary Team."

Under Section C.1.

Monitor's consultants met with Department of Human Services staff from November 5 to 7, 2013. The consultants requested a copy of the MSHS-Cambridge's "Therapeutic Interventions and Emergency Use of Personal Safety Techniques" procedure. The new version was signed November 8, and provided November 12, 2013.

[6] Email from Christina Baltes, Jensen Compliance Officer, and November 12, 2013 MSHS-Cambridge Memo, titled "MSHS-Cambridge Procedures Update," dated and effective November 12, 2013.

3. d. "Prone restraint is prohibited because positional asphyxiation is a risk factor. The prone restraint (face down) position is only allowed as a transitory position if a client rolls into such position. If a client rolls face down during a restraint they must immediately be moved to a side lying position or restored to a standing position. Applying back pressure while a client is in the prone position is prohibited."	3. d. "Prone restraint is prohibited because positional asphyxiation is a risk factor. The prone restraint (face down) position will only be used at METO as a transitory take down portion of a manual restraint procedure. The client should be rolled into a side-lying position or seated position as quickly as is possible. In addition, it is considered a transitory prone facing portion of a restraint if during a brief physical holding of an individual he or she rolls into a prone facing position, when staff restore the individual to a standing, sitting, or side-lying position as soon as possible. Applying back pressure while a client is in the prone position is prohibited."
4. k. "Efforts to lessen or discontinue the restraint must be made at least every 15 minutes unless contraindicated and these efforts must be documented. #DHS 3654 form must be used to document these efforts at release. At fifteen (15) minutes following application of restraints, staff will speak with the client and attempt to ascertain whether the client will safely comply with staff efforts to release the restraint on **ankle**. If the client indicates a willingness to comply, as evidence by no struggling and no verbal threats, staff will release the restraint on **ankle**. If the client indicates unwillingness to comply safely with the attempt to loosen the restraint, staff will continue the restraint and document the unsuccessful attempt on #DHS 3654." (emphasis added)	4. k. "Efforts to lessen or discontinue the restraint must be made at least every 15 minutes unless contraindicated and these efforts must be documented. METO form #31032 must be used to document these efforts at release. At fifteen (15) minutes following application of restraints, staff will speak with the client and attempt to ascertain whether the client will safely comply with staff efforts to release the ankle restraint. If the client indicates a willingness to comply, as evidence by no struggling and no verbal threats, staff will release the ankle restraint._If the client indicates unwillingness to comply safely with the attempt to loosen the restraint, staff will continue the restraint and document the unsuccessful attempt on METO Form #31032 (Use of Controlled Procedure Form).

5. l. " Restraint will be continued for the least amount of time necessary to bring the client's behavior under control. The maximum duration for a single episode of restraint without opportunity for mobility or exercise is 50 minutes. If after three (3) consecutive 15-minute offers to discontinue restraint the client continues to struggle and/or verbalize intent to resume behavior which creates an imminent risk of physical harm, staff will nonetheless discontinue use of manual restraint. If and only if the client's conduct again constitutes an emergency, staff will reinitiate the restraint. Verbal threats alone are insufficient reason to reinitiate restraint. If the client appears calm for 60 seconds, staff will speak with the client and attempt to ascertain whether the client will safely comply (i.e. verbalizes he or she does not intend to engage in imminent risk of physical harm to self or others) with release from restraint. If the client indicates a willingness to comply, as evidenced by no struggling and no verbal threats to cause imminent risk of physical harm to self or others, staff will release from restraint. If the client re-escalates and again engages in behavior constituting an emergency, staff will re-apply restraint per the above procedures. If restraint is reimposed, the Third Party Expert must again be consulted. The client must be given an opportunity for release from the manual restraint and for motion and exercise of the restricted body parts for at least ten (10) minutes out of every sixty (60) minutes.	5. l. "Restraint will be continued for the least amount of time necessary to bring the client's behavior under control. The maximum duration for a single episode of restraint without opportunity for mobility or exercise is 50 minutes. If after three (3) consecutive 15-minute offers to discontinue restraint the client continues to struggle and/or verbalize intent to resume behavior which creates an imminent risk of physical harm, staff will nonetheless remove the mechanical restraints or discontinue use of manual restraint. If and only if the client's conduct again constitutes an emergency, staff will reinitiate the restraint. Verbal threats alone are insufficient reason to reinitiate restraint. If the client appears calm for 60 seconds, staff will speak with the client and attempt to ascertain whether the client will safely comply (i.e. verbalizes he or she does not intend to engage in imminent risk of physical harm to self or others) with release from restraint. . If the client indicates a willingness to comply, as evidenced by no struggling and no verbal threats to cause imminent risk of physical harm to self or others, staff will release from restraint. If the client re-escalates and again engages in behavior constituting an emergency, staff will re-apply restraint per the above procedures. If restraint is reimposed, the Third Party Expert must again be consulted. The client must be given an opportunity for release from the manual or mechanical restraint and for motion and exercise of the restricted body parts for at least ten (10) minutes out of every sixty (60) minutes.
6. q. "The Facility shall not use Mechanical Restraint."	6. q. "The Facility shall not use Mechanical Restraint except Velcro soft cuffs and fabric ankle straps may be used only when an emergency."

Section D: Reporting and reviewing emergency use

7. 5.a. "*Within 14 calendar days*, after the use of restraint, members of the IDT must confer to discuss the following: . . . " [incident description, antecedent, plan to reduce behavior, modifications to individual plan, attempts to use less restrictive alternatives] (emphasis added)	7. 5.a. [Same – see below re suggested modification re timing]

8. 5.d. "The Designated Coordinator shall ensure that the plan for reducing the behavior that caused the emergency, as well as changes made to the adaptive skill acquisition portion of the plan are incorporated into the Program Plan *within 15 calendar days after the IDT review above.* (emphasis added).	8. 5.d. . [Same – see below re suggested modification re timing]
[Paragraphs 1 through 4. The New Procedure includes detail on fax/email of notice of restraint which is absent from the Original Procedure. The two procedures reference the now-relevant form numbers to be completed. The original Behavior Management Review Committee is now called the "Internal Review Committee."]	

IV. Accepted Revisions

Following are the Court Monitor's comments keyed to the Paragraph numbers in the table above. Under each comment, there is a statement of how DHS has today corrected the issues identified by the Monitor in the draft of this Report.

¶2. This is the only place in the policy which uses the term "Mental Health Professional." MSHS-Cambridge is a facility for individuals with developmental disabilities; its successors will be no different in this regard. The Settlement Agreement stresses best practices and positve behavior supports, with use of behavior analysts with proper credentials. "Mental Health Professionals" should not manage Cambridge programs (and, the Monitor believes, do not manage the programs).

The new policy reflects the proper title, "Qualified Developmental Disabilities Professional (QDDP).

¶4. Maintaining the references to "ankle" restraints contradicts the text. The 15 minute period before speaking with the client about releasing the restraint is a holdover from lengthy mechanical restraint use. Cambridge's experience with manual restraint is that it has been released typically within just a few minutes, and no longer than 10 or 15 minutes.

The new policy deletes the "ankle" restaint references. The time forlessen or discontinue restraint is reduced to every two minutes.

¶5. With the prohibition on mechanical restraints, a maximum duration of restraint of 50 minutes seems excessive and, based on this past year's experience, unrealistic. With a 15 minute maximum, and 5 minute offers of release, there is no need for the 10 minute exercise break.

The maximum duration under the new policy is reduced to 15 minutes, with continuous 2 minute offers to discontinue. The time for exercise is reduced to 5 minutes out of every 20 minutes. The

Monitor assumes that the 20 minutes is intended to mean 15 minutes and this will be corrected.

¶¶ 8 and 9. These provide 15 days for the essential post-restraint team meeting and an additional 15 days to incorporate changes into the individual's Program Plan, a total of 30 days. Lengths of stay at MSHS-Cambridge and its successors will are planned to hover in the 90 day area. Considering the reducing Cambridge census, that successors will be small, and that Program Plans are all digital, these periods should be sharply reduced.

The new policy provides for a 5 working day limit for the post-restraint team meeting, and an additional 2 working days to incorporate changes into the individual's Program Plan.

The separate reporting/notice form references prohibited restraint techniques such as prone restraint. Inclusion of these references might imply approval to some staff.

DHS has also deleted references to prone and other prohibited restraint on the separate reporting form.

The Court Monitor recommends that:

- DHS' revision of Attachment A be APPROVED by the Court.

- All current and future staff be specially trained in the revisions to Attachment A, including staff at MSHS-Cambridge and the successor programs. For current staff, the training be completed within thirty (30) days of the Court's approval order. Also, that the Court Monitor be provided with an advance written summary of the training and, for the current staff, sign-in sheets showing that all staff have been trained.

V. Conclusion

It is respectfully submitted that the above referenced revision to the Restraint Policy be approved and adopted as a replacement to Attachment A to the Settlement Agreement, and that the further recommendations for training and approval of the revision be adopted.

Dated _____ /s David Ferleger
Court Monitor

EXHIBIT A

From: **Shamus O'Meara** SPOMeara@olwklaw.com
Subject: RE: DRAFT REPORT TO COURT - REVISION TO ATT. A TO SETTLEMENT AGREEMENT
Date: December 2, 2013 at 8:09 AM
To: David Ferleger david@ferleger.com, Alpert Steve H. Esq. Steve.Alpert@ag.state.mn.us, Tessneer Mike mike.tessneer@state.mn.us, Annie Santos MASantos@olwklaw.com, McElroy Elizabeth(Betsy) betsy@sbmcelroy.com, Ikeda Scott Scott.Ikeda@ag.state.mn.us, Opheim Roberta roberta.opheim@state.mn.us, Akbay Amy Esq. amy.akbay@state.mn.us, Wieck, Ph.D. Colleen colleen.wieck@state.mn.us, DHS Baltes (DHS) christina.baltes@state.mn.us, Steve (DHS) Jensen A steve.jensen@state.mn.us
Cc: Office David Ferleger of office@ferleger.com, McElroy Elizabeth(Betsy) betsy@sbmcelroy.com

Dear Mr. Ferleger:

The Settlement Class supports the elimination of the emergency exception use of Velcro soft cuffs and fabric ankle straps as referenced in the parties' proposed stipulation previously submitted to the Court as well as the deletion of references to the use of prohibited prone restraint and any other prohibited restraint as suggested in the draft report. The Settlement Class does not support the proposed DHS language in red color referenced in the comparison chart in the draft report.

O'MEARA LEER WAGNER KOHL
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AV PREEMINENT® 2013
Shamus P. O'Meara

From: David Ferleger [mailto:david@ferleger.com]
Sent: Monday, November 18, 2013 5:13 PM
To: Alpert Steve H. Esq.; Shamus O'Meara; Tessneer Mike; Annie Santos; McElroy Elizabeth(Betsy); Ikeda Scott; Opheim Roberta; Akbay Amy Esq.; Wieck, Ph.D. Colleen; DHS Baltes (DHS); Steve (DHS) Jensen A
Cc: Office David Ferleger of; McElroy Elizabeth(Betsy)
Subject: DRAFT REPORT TO COURT - REVISION TO ATT. A TO SETTLEMENT AGREEMENT

Dear Colleagues,

Attached is a DRAFT of my report to the Court on revision of Attachment A to the Settlement Agreement (the restraint policy). The 3 versions of that policy are also attached.

My hope is that the final report will reflect the parties' agreement.

I request the parties to disagree, or to concur, or to suggest alternatives, with regard to the indicated problematic language.

Your responses are due within 10 days.

EXHIBIT B

Minnesota Department of **Human Services** — **Memo**

DATE: December 6, 2013

TO: David Ferleger
Jensen Settlement Agreement Court Monitor

FROM: Christina Baltes, RN, PHN, BSN, MA, QDDP/QIDP.
Jensen Settlement Agreement Compliance Officer

SUBJECT: Report on Attachment A to the Jensen Settlement Agreement-MSHS-Cambridge Restraint Policy

Thank-you for the opportunity to respond to your November 18, 2013 e-mail and attachment called, "Report on Attachment A to the Jensen Settlement Agreement-MSHS-Cambridge," and for your extension of the response due date to December 6, 2013.

We have reviewed your suggestions in the report and have attached a revised "Therapeutic Interventions and Emergency Use of Personal Safety Techniques" policy that reflects the following changes:

1) Item #2 page 3: Supervision of the Mental Health Professional: The new policy correctly reflects the current title which is "Qualified Developmental Disabilities Professional (QDDP)"
2) Item #4 page 4: Section C 1. k. The time for "efforts to lessen or discontinue the restraint" was reduced to every 2 minutes and the words "on ankle" was removed.
3) Item #5 on page 5: Section C 1. l. The maximum duration was reduced to 15 minutes and 2 minutes and the time for motion and exercise was reduced to 5 minutes out of every 20 minutes.
4) Item #8 page 5: Section D 5. a. The time frame was reduced to 5 working days or fewer.
5) Item #8 page 5: Section D 5. d. The time frame was reduced to 2 working days.

We have deleted references to the use of prone restraint and any other prohibited restraint in the separate reporting/notice form (attached). We would appreciate calling this the reporting/notice form rather than using a number.

We understand that this is a draft. However, in the spirit of cooperation, we thought we should bring to your attention the following:

There are 2 items #2 listed-one on page 3 and one on page 4.

For item #5 on page 5, it appears that the second column was numbered #6 potentially in error. This leads to the next column being labeled #7.
Page 2, Last line, second paragraph under the following title: "II. The 2012 Agreement to Revise the Restraint Policy Was Not Adopted" has a sentence that appears to be missing a reference.
Page 2, Subscript 1, there appears to be a repeat of the statement, "The procedure has been re-issued twice since the approval of the Settlement."
Page 3, Christine Baltes should be Christina Baltes

I would like to thank-you again for the opportunity to comment and for the extension of the due date.

Cc via e-mail: Steve Alpert, Assistant Attorney General
Shamus O. Meara, Plaintiffs' Counsel
Michael Tessneer, DHS Staff
Annie Santos Esq., Plaintiffs' Counsel
Elizabeth McElroy, Court Monitor's Staff
Scott Ikeda, Assistant Attorney General
Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities
Amy Akbay, General Counsel, DHS
Colleen Wieck, Executive Director of the Minnesota Governor's Council on Developmental Disabilities
Steve Jensen, MSHS-Cambridge
Anne Barry, Deputy Commissioner, DHS

Effective Date: December 4, 2013 Procedure Number: 15868

Minnesota Specialty Health System – Cambridge

CLIENT CARE

THERAPEUTIC INTERVENTIONS AND EMERGENCY USE OF PERSONAL SAFETY TECHNIQUES

DCT REFERENCE POLICY NUMBER: __6260_____

BACKGROUND:
MSHS-Cambridge uses positive behavior support strategies as its core means for encouraging alternate behaviors in place of behaviors that inhibit a client's ability to live sustainably in the community. Essential to this approach is fostering and sustaining an environment in which positive behavior support (PBS) strategies are utilized, as well as alternate modalities and methods of communication to assist clients to better meet their needs and have more control over the behaviors that inhibit a client's ability to live sustainably in the community. MSHS-Cambridge prohibits the use of any aversive or deprivation procedures as interventions in a client's Individual Program Plan or equivalent program plan documentation.

PURPOSE:
Even within the framework of positive behavior support programming in the Program Plan, there are emergencies in which less restrictive behavioral support strategies are ineffective in sustaining safety. When an emergency occurs, it is incumbent on staff to assure the individual's and others' safety in the moment. MSHS-Cambridge defines these emergencies as situations where the client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Client refusal to receive/participate in treatment shall not constitute an emergency.

The *only* time a restraint will be used at MSHS-Cambridge, will be as a safety measure when treatment has failed and an emergency results. The only type of emergency restraint permitted at MSHS-Cambridge is certain specified manual restraints. MSHS-Cambridge shall use the least amount of intervention necessary to safely physically manage an individual, only when less restrictive behavioral support strategies have been ineffective in sustaining safety, and only concurrent with the uncontrolled behavior. These procedures will be continued for the least amount of time necessary to bring the individual's behavior under control and be appropriate to the situation to ensure safety.

Whenever possible, staff shall first attempt to de-escalate these emergencies by implementing the client's Program Plan with specific references to less restrictive alternatives that are known to help that client de-escalate, as well as through negotiation, redirection, distraction, and modifications to the environment all of which are likely to assist the client to utilize alternate behaviors to meet their needs. Restraint shall not be used for disciplinary purposes, for the convenience of staff, or as a substitute for treatment, nor shall restraint be used to compel clients to receive/participate in treatment. MSHS-Cambridge has a zero tolerance for misuses of emergency risk reduction procedures and will take appropriate corrective and/or disciplinary action when such misuses are identified.

DEFINITIONS:
Client: An individual receiving treatment at MSHS-Cambridge.

Responsible Supervisor: Home Supervisor, Work Supervisor, Administrator on Duty (AOD), or Lead Worker on Duty.

Designated Coordinator the Designated Coordinator is responsible for much of the rest of the intake documentation. The Designated Coordinator collaborates with other team members to produce the client's IPP, under the supervision of a Qualified Developmental Disabilities Professional, (QDDP).

Staff Certified in Therapeutic Intervention and Personal Safety Techniques: A staff member who has successfully completed the State Operated Services standardized and facility approved "Therapeutic Intervention" and "Personal Safety Technique" courses within the past year or taken a "Therapeutic Intervention" and "Personal Safety Technique" refresher classes within the last year.

Therapeutic Interventions: A form of intervention which consists of early identification of potential emergencies; prevention of emergencies through verbal, non-verbal, and nonphysical methods; diversion by providing choices to clients or alternate activities, environments or personal contacts. Prevention is predicated on identification of individual client needs, planning to meet those needs, and the use of specific de-escalation techniques in the client's Program Plan.

Personal Safety Techniques (PST): Application of external physical control by employees to a client only when a client causes an emergency despite the preventive therapeutic intervention strategies attempted. Physical control is based on the principle of using the least amount of force necessary to prevent injury and protect life and physical safety when positive behavior programming and other less restrictive prevention strategies have failed.

Manual Restraint: "Manual restraint" means physical intervention intended to hold a client immobile or limit a client's movement by using body contact as the only source of physical restraint. It is any manual method that restricts freedom of movement or normal access to one's body, including hand or arm holding to escort an individual over his or her resistance to being escorted. The term *does not mean* physical contact used to: facilitate the client's completion of a task or response when the client does not resist or the client's resistance is minimal in intensity and duration; conduct necessary to perform medical examination or treatment; response blocking and brief redirection used to interrupt an individual's limbs or body without holding a client or limiting his or her movement; or holding an individual, with no resistance from that individual, to calm, or comfort.

Mechanical Restraint: Mechanical restraints are prohibited. "Mechanical restraint" means the use of a device to limit a client's movement or hold a client immobile as an intervention precipitated by a client's behavior. The term does not apply to devices used to treat a client's medical needs to protect a client known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a client with physical disabilities in a manner specified in the client's Program Plan.

Emergency: Situations when the client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety. Client refusal to receive/participate in treatment shall not constitute an emergency.

Interdisciplinary Team: Interdisciplinary team means a team composed of: the client receiving treatment from MSHS-Cambridge; his or her case manager; his or her legal representative and advocate, if any; representatives of providers of residential, day training and habilitation, and support services identified in the client's Program Plan; a health professional, if the client has overriding medical needs; mental health professionals (e.g. Psychologist, Psychiatrist, Counselor) if the client has overriding mental health needs; and a designated coordinator. The designated coordinator must have at least one year of direct experience in assessing, planning, implementing, and monitoring a plan that includes a behavior intervention program.

Program Plan: A plan developed by the Interdisciplinary Team, outlining positive behavior support strategies as the course of treatment intervention intended to encourage alternate behaviors in place of those behaviors that inhibit a client's ability to live sustainably in the community. This plan is developed using the information garnered from a thorough assessment of the function of the undesired behaviors, as well as person centered planning principles consistent with *Olmstead v. L.C.*, 527 U.S. 582 (1999), in order to assist the Interdisciplinary Team in creating treatment interventions that will effectively help the client get his or her needs met by alternate methods.

Prone Restraint: Prone restraints are prohibited. "Prone restraint" means any restraint that places the individual in a facedown position. Prone restraint does not include brief physical holding of an individual who, during an incident of physical restraint, rolls into a prone or supine position, when staff restore the individual to a standing, sitting, or side-lying position as soon as possible.
Restraint: Means the use of manual, mechanical, prone, or chemical restraint.

Chemical Restraint: Chemical restraints are prohibited. Is the administration of a drug or medication when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's condition. Orders or prescriptions for the administration of medications to be used as a restriction to manage the client's behavior or restrict the client's freedom of movement shall not be written as a standing order or on an as-needed basis (PRN).
Seclusion: Seclusion is prohibited. Means the placement of a client alone in a room from which egress is:

a. non-contingent on the client's behavior; or
b. prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the client from leaving the room.

Time Out: Means removing a client from the opportunity to gain positive reinforcement and is employed when a client demonstrates a behavior identified in the individual program plan for reduction or elimination. Room time out means removing a client from an ongoing activity to a room (either locked or unlocked).

RESPONSIBILITIES & PROCEDURES:

A. Assessments

1. Development of the Program Plan: Following admission, the Designated Coordinator for the client's Interdisciplinary team, with the assistance of all other team members will obtain information about the client that could help minimize the use of restraint by identifying the following:
    a. Techniques that would help the individual control his or her behavior.
    b. The client's need for methods or tools to manage his or her behavior.
    c. Pre-existing medical conditions or any physical disabilities and limitations that would place the individual at greater risk during the use of restraint (see section on "Admission History and Physical and Annual History and Physical assessments").
    d. Any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during restraint.
    e. Techniques identified by the client or his or her family that would help minimize the use of restraint.
2. Admission History and Physical and Annual History and Physical assessments: MSHS-Cambridge RN's shall ensure that all MSHS-Cambridge clients are assessed by a physician or advanced practice RN (APRN) or nurse practitioner (NP) during the admission physical and at least annually thereafter to determine whether the client has a physical condition, i.e., obesity, asthma, etc., which would make implementation of any restraint medically contraindicated. The physician's statement regarding contraindication of these procedures shall be included in the admission history and physical report, the doctor or APRN's admitting orders (treatments,

diagnostic procedures, and administration of medications that must be carried out by a nurse upon written order), and annual physical examination report. Alternatives and/or means under which restraint might be used when there is a medical contraindication will be written as an identifiable treatment order on the client's medical record physician order sheet.

B. Staff Training on Therapeutic Interventions and Emergency Restraint

1. Upon employment, all MSHS-Cambridge staff members shall complete the full SOS Therapeutic Interventions and Personal Safety Techniques (TI/PST) course and Positive Behavior Supports course. This training will consist of:
   a. Upon start of employment and annually thereafter, staff are trained in early detection of escalation by an individual during the 12 or more hours of training per year on Positive Behavior Supports (varying based on the length needed to complete computer based portions and test outs of the training).
   b. Upon start of employment, each staff must complete a16 hour orientation training with mandatory skill check-off and certification. This includes 8 hours of training in therapeutic intervention (including boundaries and negotiation) and 8 hours of training in personal safety techniques. This curriculum includes therapeutic boundaries and risk reduction negotiation techniques.
   c. Semi-annually thereafter, or more often if assigned by supervisor, each staff must complete 8 hours of training (4 hours of training in therapeutic intervention, including boundaries and negotiation, and 4 hours of training in personal safety techniques), with mandatory skill check-off and certification.
      (1) Recommended SOS certified TI/PST instructor to student ratio for refresher training is 2 to 15.
2 Required level of proficiency: Employee will be able to accurately and independently demonstrate in role play use of therapeutic interventions as documented by a SOS certified TI/PST instructor.
3. All training of employees in Therapeutic Intervention shall be conducted by SOS certified therapeutic intervention instructors.
4. Staff are trained in early detection of escalation for a particular individual, through client specific training on their program plans and what positive behavior support strategies are known to assist a particular client in de-escalation. The Designated Coordinator is responsible for assuring this client specific training occurs every time the IDT modifies the client's Program Plan.

C. Implementation of Therapeutic Interventions and Emergency Restraint:

1. When staff perceive warning signs of a potential emergency they should:
   a. Attempt to utilize Therapeutic Intervention techniques, positive behavior support strategies that are known to work for the individual, or other alternatives or de-escalation strategies to reduce the need for restraint. The focus of the therapeutic interventions is in early detection of escalation of risk taking behavior. Staff will then utilize positive behavior support techniques known to assist a particular client to de-escalate according to their Program Plan
   b. Ensure, if possible, a 4'x6'mat and a mat for the client's head area is available and used to provide safeguard to the client during those restraints that have a client lay on the floor. Mats are located and available in all areas of the campus where client activities occur. Since these mats are located in areas where they are readily available and staff are trained in early detection of escalation by an individual through the annual Positive Behavior Supports training, training on the use of Therapeutic Interventions, or by specific training on a client's Program Plan and what techniques

are known to assist a particular client in de-escalation, it is likely that these mats will be ready for use in emergency situations. If staff are unable to guide the client directly onto the mat or the mat is not readily available, once the client is immobilized the mat will be placed under their body or they will be rolled into a side lying position onto the mat. The small mat will be placed under the client's head if their head is not on the larger mat.

c. Only initiate the use of restraint if trained in its use, and use only facility approved physical intervention techniques and holds.

d. Prone restraint is prohibited because positional asphyxiation is a risk factor. The prone restraint (face down) position is only allowed as a transitory position if a client rolls into such position. If a client rolls face down during a restraint they must immediately be moved to a side lying position or restored to a standing position. Applying back pressure while a client is in the prone position is prohibited.

e. Notify the RN and/or Lead Worker On Duty immediately.

f. Notify the responsible supervisor immediately.

g. Make sure a #DHS 3654 (Documentation for Emergency Use of Manual Restraint and Notification of Incident) is initiated as soon as is possible following initiation of restraint.

h. During the use of a restraint, continuously monitor the client's physical condition closely for signs of distress (cardiac, respiratory, circulation, choking, seizure onset) and take immediate action to discontinue restraint and provide emergency first aid (including calling 911) if distress is noted. Take vital signs if directed by RN. Document the results of this monitoring every 15 minutes on #DHS 3654 form.

i. As soon as reasonably possible upon the emergency presenting, but no later than 30 minutes after the emergency begins, the responsible supervisor shall contact a Third Party Expert from a pre-approved list. The expert shall be consulted in order to obtain professional assistance to abate the emergency condition, including the use of positive behavioral support techniques, safety techniques, and other best practices. If the scheduled qualified Third Party Expert is not immediately available, the responsible supervisor shall contact the Department's medical officer on call in order that the medical officer may assess the situation, suggest strategies for de-escalating the situation, and approve of or discontinue the use of restraint. The consultation with the Third Party Expert or medical officer shall be documented in the client's medical record.

j. During the use of a restraint, timing of checks, prompts, and additional procedural steps begin with the point in time at which the client is immobilized. At this point, staff will inform the client of the release criteria. Release criteria for emergency restraint are sixty (60) seconds wherein (1) the client is physically calm, and (2) without verbal threats/indication of intent to resume imminent risk of physical harm to self or others.

k. Efforts to lessen or discontinue the restraint must be made at least every 2 minutes unless contraindicated and these efforts must be documented. #DHS 3654 form must be used to document these efforts at release. Staff will speak with the client immediately upon application of the procedure, and continually at intervals not to exceed 2 minutes and attempt to determine whether the client will cooperate with staff to enable the safe release of the restraint. If the client indicates a willingness to cooperate, as evidence by no struggling and no verbal threats, staff will release the restraint. If the client indicates unwillingness to comply safely with the attempt to loosen the restraint, staff will continue the restraint and document the unsuccessful attempt on #DHS 3654 (Documentation for Emergency Use of Manual Restraint and

Notification of Incident).

l. Restraint will be continued for the least amount of time necessary to bring the client's behavior under control. The maximum duration for a single episode of restraint without opportunity for mobility or exercise is fifteen (15) minutes. If after fifteen minutes and continuous offers at least every 2 minutes to discontinue restraint the client continues to struggle and/or verbalize intent to resume behavior which creates an imminent risk of physical harm, staff will nonetheless discontinue use of manual restraint. If and only if the client's conduct again constitutes an emergency, staff will reinitiate the restraint. Verbal threats alone are insufficient reason to reinitiate restraint. If the client appears calm for 60 seconds, staff will speak with the client and attempt to ascertain whether the client will safely cooperate (i.e. verbalizes he or she does not intend to engage in imminent risk of physical harm to self or others) with release from restraint. If the client indicates a willingness to cooperate, as evidenced by no struggling and no verbal threats to cause imminent risk of physical harm to self or others, staff will release from restraint. If the client re-escalates and again engages in behavior constituting an emergency, staff will re-apply restraint per the above procedures. If restraint is re-imposed, the Third Party Expert must again be consulted and the same protocols for communicating with the client and the same release procedures will be applied. The client must be given an opportunity for release from the manual restraint and for motion and exercise of the restricted body parts for at least five (5) minutes out of every twenty (20) minutes.

m. If at any time during use of a restraint staff believe the health or safety of either the client or staff is in jeopardy because of the restraint, staff shall immediately release the client. If it looks like the aggregate time of restraints may exceed 15 minutes, the responsible supervisor shall be asked to conduct an immediate assessment and will do so in consultation with the on call Medical Director or on call Administrator for the program. The responsible supervisor with training/experience working with developmentally disabled adults with comorbid mental health conditions, will assess whether the client's mental health condition is causing him or her to engage in imminent risk of physical harm to self or others and subsequently if there is a need to contact a physician to request the use of a previously prescribed psychotropic medication to manage the client's mental health symptoms more effectively and minimize the need for further restraint to keep the individual safe (MSHS-Cambridge Procedure #15904).

n. Following the client's release from the use of restraint, staff should:
   (1) Provide immediate care for any client injuries incurred.
   (2) Assume the occurrence of using restraint may have been traumatic for the individual and debrief with them as he or she permits.
   (3) Try to get the client integrated back into his or her normal routine as quickly as possible.
   (4) Complete required documentation including #DHS 3654 form.

o. The Facility shall not use Chemical Restraint.

p. The Facility shall not use Seclusion or Time Out.

q. The Facility shall not use Mechanical Restraint.

r. Medical restraint and psychotropic and/or neuroleptic medications shall not be administered to clients for punishment, in lieu of adequate and appropriate habilitation, skills training and behavior supports plans, for the convenience of staff and/or as a form of behavior modification.

D. Reporting and reviewing emergency use.

Any use of restraint must be reported and reviewed as specified in the following items:

1. Staff member who implemented the procedure:
   a. Complete required documentation including #DHS 3654 form. This form must be completed before the end of each staff's shift.
   b. A client Incident Report (see SOS Policy 2020 Incident Reporting and Management) shall be completed if the client experienced any physical injury.
2. Nursing/Designee:
   a. Review and complete designated nursing sections of #DHS 3654 form.
   b. Ensure that the completed #DHS 3654 form summarizes the opinions of the private vendor who was consulted.
3. Supervisor/AOD/Lead Worker on Duty:
   a. Review and complete designated supervisory sections of #DHS 3654 form.
   b. Ensure that the completed #DHS 3654 form summarizes the opinions of the private vendor who was consulted.
   c. Ensure that the completed original of #DHS 3654 form is delivered to the HIMS collection area before the end of the shift on which the restraint occurred.
   d. Complete an Employee Injury/Illness Notification Form if any staff experience an injury and deliver to supervisor/supervisor on-call by the end of the shift.
   e. The completed # DHS 3654 from shall be submitted electronically, faxed or personally delivered (through the United States Postal Service [USPS]) to the following offices or persons. A reasonable effort must be made to submit it within 24 hours, but in no event later than the next business day. See I:\Programs\MSHS-Cambridge\GEN\Forms\Client Medical Record\Client Medical Record (DHS Forms)\ Notification Info-EUCP, PRN Use, 911 Calls/.
      - DHS Internal Reviewer
      - DHS Licensing
      - Ombudsman for Mental Health & Developmental Disabilities
      - Office of Health Facility Complaints
      - Plaintiff's Counsel
      - Legal Representative
      - County Case Manager
      - Court Monitor
      - Director of Operations Support
      - Compliance Office, Special Projects
      - CEO, State Operated Services
      - MSHS-Cambridge Site Director
      - Commissioner's Office, Jensen Compliance Officer
      - Attorney General (2)
   f. If it is discovered that information has been sent to the wrong e-mail address, fax number or USPS mailing address, you must report the error immediately.
      (1) Notify DHS Data Privacy Official – (651) 746-4743
      (2) Notify SOS Health Information Management Services (HIMS).
         (a) SOS HIMS Director at (651) 295-2302; and
         (b) SOS Assistant HIMS Director at (612) 390-5626
      (3) Include the following details in the notification:
         (a) Who the e-mail, fax or letter was sent to
         (b) What documents or information were sent
         (c) The date the e-mail, fax or letter was sent
         (d) The date it was discovered
         (e) If the e-mail was successfully recalled

(4) Complete the DHS Privacy - Security Complaint or Incident Report Form 2008 (available on the iNET under Forms/SOS (non-Medical Record) Policy Forms. Submit the form to the DHS Data Privacy Official, SOS HIMS Director and SOS Assistant HIMS Director.

g. This procedure and referenced process have been reviewed by SOS HIMS personnel and have been deemed to meet HIPAA requirements for privacy.

4. Scan form #DHS 3654 and send copies to the MSHS-Cambridge Director and the client's program team. A reasonable effort must be made to submit it within 24 hours, but in no event later than the next business day.
   a. Submit a copy of the Emergency Use of Controlled Procedure Report to the Internal Review Committee (IRC), the DHS internal reviewer, and as otherwise required by law within five working days after the IDT review of the emergency use of restraint.
5. Designated Coordinator:
   a. **Within five (5) working days, or fewer,** after the use of restraint, members of the IDT must confer to discuss the following:
      1) The incident that necessitated the use of restraint
      2) A description of the imminent risk of physical harm to self or others and the plan for reduction or elimination of this behavior in observable and measurable terminology
      3) Identify the antecedent or event that gave rise to the imminent risk of physical harm to self or others
      4) Identify the perceived function the imminent risk of physical harm to self of others served
      5) Determine what modifications should be made to the existing Individual Program Plan to reduce the need for future use of an emergency manual restraint.
      6) Documentation of attempts to use less restrictive alternatives.
   b. The Designated Coordinator will document any recommendations the IDT makes in regards to 1-6 above on MSHS-Cambridge Form #DHS 3653 and submit the completed form to HIMS. The HIMS department shall then forward the original to the client's permanent medical record and to the Internal Review Committee.
   c. The Designated Coordinator will identify in the client's Program Plan any recommendations the IDT makes in regards to 1-6 above.
   d. The Designated Coordinator shall ensure that the plan for reducing the behavior that caused the emergency, as well as changes made to the adaptive skill acquisition portion of the plan are incorporated into the Program Plan no later than two (2)working days after the IDT review above. The Designated Coordinator shall document the decisions of the IDT in the client's permanent record. During this time, the Designated Coordinator shall document all attempts to use less restrictive alternatives including:
      (1) strategies that were not successful in reducing the client's engagement in imminent risk of physical harm to self or others;
      (2) attempts made at less restrictive procedures that failed and why they failed; and
      (3) rationale for not attempting the use of other less restrictive alternatives.
   e. The Designated Coordinator for each client shall be responsible to monitor the repeated use of restraint. When restraint occurs more than twice in 30 days for an individual client, it must be reviewed by the IDT, MSHS-Cambridge Director or designee, and the DHS internal reviewer to determine if any modifications or adjustments to the program plan would be warranted.

5. Internal Review Committee (IRC) The IRC reviews completed #DHS 3653 and #DHS 3654 forms at its regularly scheduled meeting and identifies any concerns they might have regarding the use of restraint and document them in the IRC minutes.
6. Critical Action-Review of Experience (CARE) Any time additional staff are needed for intensive negotiations or use of restraint, a CARE meeting will be attempted. Attendance at the CARE meetings is voluntary, confidential and will be used only for information gathering. Facilitators for these meetings are volunteer Human Services Support Specialist and clinical staff. Information will be gathered on what went well during the critical action (so this can be replicated) and identify where staff were not as effective, so that the program can determine alternative prevention measures that can be applied across the program, determine if additional staff training is needed, and provide a communication channel and suggestions for the involved staff to MSHS-Cambridge Administration. Completed CARE information will be submitted to the MSHS-Cambridge Director and assigned CARE review team for review and follow up with the respective MSHS-Cambridge program teams, SOS Therapeutic Intervention instructors, or the Internal Review Committee.
7. HIMS shall maintain statistics on the use of restraints. For each use of restraint it shall record: the client's name, the date of the restraint, the type of restraint used, and the length of time the restraint was used. This information shall be provided to the Director and DHS [Internal Reviewer] monthly.

DATA PRIVACY: Staff must ensure compliance with state and federal data privacy regulations.

REFERENCES:

- State Operated Services Policy 6260, Therapeutic Intervention
- MSHS-Cambridge Procedure #15904 – Administration of Psychotropic Medication to Persons with Developmental Disabilities
- DHS# 3654 – Psychotropic PRN Medication Use Report, Documentation for Emergency Use of Manual Restraint, Emergency/911 Call Documentation and Notification of Incident Form
- DHS# 3653 – Expanded Interdisciplinary Team Documentation Form

CANCELLATIONS: This procedure supersedes MSHS-Cambridge Procedure #15868 dated November 12, 2013.

AUTHENTICATION SIGNATURES:

Steven Jensen,
Minnesota Specialty Health System – Cambridge Director

12/4/13
Date

State Operated Services

☐ *PSYCHOTROPIC MEDICATION PRN USE AND CRITERIA (Complete Pages 1-2)** ☐ *DOCUMENTATION FOR EMERGENCY USE OF MANUAL RESTRAINT (Complete Pages 3-5)* ☐ *911 CALL DOCUMENTATION (Complete Pages 6-7)* ☐ *NOTIFICATION OF INCIDENT (Complete Pages 8-9)*	* ☐ *Copy of Client Specific Psychotropic PRN Criteria attached*

PSYCHOTROPIC PRN MEDICATION USE

Date of Use: *Client Specific Psychotropic PRN Criteria (DHS-3703) dated .

1. Signs or objective evidence of psychiatric symptom(s) leading to risk of significant physical injury and/or psychological /emotional anguish. Include precipitating factors and events leading to psychotropic PRN administration and alternatives tried per Client-Specific Psychotropic PRN Criteria.

2. Approved criteria for PRN administration reviewed with Lead Worker/designee to ensure Psychotropic PRN Criteria alternatives were used.

Lead Worker/designee Name: **Time:** ☐ AM ☐ PM

3. [MSHS-Cambridge Only]

Psychotropic PRN Criteria Reviewed with RN: **Approval** ☐ **Y** ☐ **N** **RN Name:** **Time:** ☐ AM ☐ PM

If RN contacted physician: **Physician Name:** **Time:** ☐ AM ☐ PM

4. Psychotropic PRN Medication Administered

Name of Medication:

Dose Given/Route:

Time Administered: ☐ AM ☐ PM

Signature/Title of Med Administrator **Date:** **Time:** ☐ AM ☐ PM

5. Follow-Up - Within two hours, describe psychiatric symptom(s) after the psychotropic PRN medication was administered.

Signature/Title of Med Reviewer **Date:** **Time:** ☐ AM ☐ PM

6. Notifications ***(Lead Worker/designee to complete)*** **Mode of Notification**

County Case Manager* **Date:** _____ **Time:** _____ ☐ AM ☐ PM ☐ Telephone ☐ Other (specify in comments)

Legal Representative **Date:** _____ **Time:** _____ ☐ AM ☐ PM ☐ Telephone ☐ Other (specify in comments)

Comments:

Signature/Title of Lead Worker: **Date:** **Time:** ☐ AM ☐ PM

☐ *Notified Case Manager that ISP must identify frequency of review for PRN use and for PRN effectiveness

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Psychotropic PRN Medication Use Report, Documentation for Emergency Use of Manual Restraint, Emergency / 911 Call Documentation and Notification of Incident

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7. RN Consultant/QDDP/Designee Review *(within 72 hours)*
Did the use of the psychotropic PRN correspond to the pre-established psychotropic PRN criteria? ☐ Yes ☐ No
If no, explain:
Signature of RN Consultant/Designee **Date:** **Time:** ☐ AM ☐ PM

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Documentation for Emergency Use of Manual Restraint (EUMR)

Date: _____	**Initiator of Intervention** *(Full name):* _____	**RN Notified:**
Time:	**Assisting Staff** *(full names)* 4) _____	_____ *(Name)*
Start: _____	1) _____ 5) _____	
End: _____	2) _____ 6) _____	**Time:** _____
Total: _____ minutes	3) _____ 7) _____	

1. Type of Risk necessitating intervention: ☐ Harm to Self ☐ Harm to Others

2. Specify personal safety technique used in intervention, if any: *(check all that apply)*

☐ Escort ☐ Group takedown ☐ Other *(specify)*:
☐ Basic come-along ☐ Sidelying hold
☐ Arm-bar come-along ☐ None

3. Specify equipment used in intervention, if any: *(check all that apply)*

☐ None ☐ Mat ☐ Other *(specify):*

4. Specify personal property removed, if any: ☐ None

5. Detailed description of the incident leading up to the use of intervention (describe with observable terms) *(e.g., conflict with family, peers, or staff, difficulty accepting limits, physical discomfort, mental health symptoms, misunderstanding/confusion)*:

6. Specific Alternatives Considered and Tried (describe with observable terms) *(e.g., offered alternative activity, restructure environment, sensory integration, talk to/listen, active negotiation)*:

7. Specific behaviors creating risk to client or others necessitating use of intervention (describe with observable terms):

8. Specific behavioral outcome that was a result from the intervention (describe with observable terms) *(e.g., cessation of behavior creating risk to self or others, reduction of target behavior per program criteria)*:

9. What is the likelihood that the behavior necessitating intervention use will recur?

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10. MANUAL RESTRAINT PROCEDURE: Efforts to Lessen or Discontinue Restraint at least every 2 minutes)

Time of Attempted Release	Pulse Respiration	Color, Motion, Sensation	Client Response *(e.g., verbal aggression, physical agitation)*	Staff Signature

Staff Signature: **Date:** **Time:**

SOS Chief Medical Officer Consulted ***(as soon as reasonably possible but within ½ hour of initiation)***

Name of Consultant: **Date:** **Time:**

Summarize consultant's advice on how to resolve the emergency or write "unavailable."

Staff Signature: **Date:** **Time:**

RN/Designee Review *(check all that apply)*:

☐ No physical injury apparent ☐ No emotional distress apparent ☐ Moderate distress, slight agitation

☐ Physical injury (describe below): ☐ Mild upset, distress, no agitation ☐ Severe agitation

Plan, if any:

RN/Designee Signature: **Date:** **Time:**

Client Debriefing

1. Reason for intervention discussed with client: ☐ Yes ☐ No

If no, explain:

2. Client's suggestions regarding how to avoid future need for intervention:

3. Client request for help in dealing with after effects of current intervention: *(check all that apply)* ☐ None

☐ Notify family ☐ Notify other team member ☐ Talk to staff ☐ Talk to others ☐ Time alone ☐ File complaint/ grievance

☐ Other *(explain):*

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4. Client engaged in active programming or other appropriate activity within 15-30 minutes: ☐ Yes ☐ No
If no, explain:

Supervisor/AOD/Lead Worker on Duty Review: **

1. Is manual restraint documented in Progress Notes? ☐ Yes ☐ No

2. Comments:

Supervisor/AOD/Lead Worker on Duty Signature: **Date:** **Time:**

Consultation with Expanded Interdisciplinary Treatment Team Following Use of Emergency Manual Restraint

Designated Coordinator Review
(within 5 working days of EUMR)

☐ **Yes** ☐ **No** _____
Date

***Mailed Notifications** (by HIMS) (within 7 days of use)*

☐ **Interdisciplinary Team** _____ *Date*

☐ **IRC** _____ *Date*

Legal Representative *(See Notifications page)*

Case Manager *(See Notifications page)*

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Emergency / 911 Call Documentation

Date 911 Call/Event Happened:	Day of Week: Time Event Happened:
Client Legal Status type:	
Risk factor identified in the Risk Management Plan? Yes ☐ No ☐ Date of Risk Management Plan:	
PRECIPITATING EVENT	
Describe what was happening before things began to escalate:	
Describe the event:	
Who called 911? Reason for calling 911: Number of Law Enforcement responding: Was Law Enforcement asked to lock up weapons? Yes ☐ No ☐ Did they comply? Yes ☐ No ☐ If not, describe:	Did Law Enforcement use Pepper spray? Yes ☐ No ☐ Electronic Control Device (Taser)? Yes ☐ No ☐ Handcuffs? Yes ☐ No ☐ Other? Yes ☐ No ☐
Was the client taken to Jail? Yes ☐ No ☐	Explain:
Was the client taken to the Cambridge Medical Center Emergency Room? Yes ☐ No ☐	Explain:
Was the client transferred to another state facility? Yes ☐ No ☐	Explain

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EVENT MANAGEMENT AND RECOVERY

What interventions were tried to de-escalate the situation?

☐ Contact with Behavioral Staff	☐ Win-win negotiation
☐ One-to-one with team member (nursing or other)	☐ Rapport
☐ Listening and talking in supportive way	☐ Other *(describe)*
☐ Client identified intervention *(describe)*	☐ Convey behavioral expectations
☐ Reduce stimuli	☐ Relaxation or diversionary measures

Was staff injured during the event? Yes ☐ No ☐
If yes, describe:

Nature of injury if occurred:

Was there a staff debriefing? Yes ☐ No ☐	Was there a client debriefing? Yes ☐ No ☐

Date completed: _____ Completed by: _____
[Print Name and Title]

Signature: _____

Time signed: _____ ☐ AM ☐ PM _____

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NOTIFICATION OF INCIDENT

NOTIFICATIONS TO BE COMPLETED WITHIN 24 HOURS OF USE BUT IN NO CASE LATER THAN NEXT BUSINESS DAY If unable to notify within 24 hours, provide explanation of reasonable effort to send by next business day under *Comments*.

OFFICE / PERSON NOTIFIED	NOTIFICATION MODE (MUST CHECK AT LEAST ONE BOX)					DATE/TIME	INITIALS
	E-Mail Scan	Fax	US Mail (Certified)	Verbal	Other *(specify)*		
DHS Internal Reviewer[1] *Comments:*	☐	☐	☐		☐		
DHS Licensing[1] *Comments:*	☐	☐	☐		☐		
Ombudsman[2] *Comments:*	☐	☐	☐		☐		
Office of Health Facility Complaints[1] **(Not applicable for MSOCS)** *Comments:*	☐	☐	☐		☐		
***Plaintiff's Counsel**[2] *Comments:*	☐	N/A	☐		☐		
Legal Representative[3] *Comments:*	☐	☐	☐	☐	☐		
County Case Manager[3] *Comments:*	☐	☐	☐	☐	☐		
***Court Monitor**[1] *Comments:*	☐	☐	☐		☐		
Compliance Office, Special Projects[1] *Comments:*	☐	☐	☐		☐		

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OFFICE / PERSON NOTIFIED	NOTIFICATION MODE (MUST CHECK AT LEAST ONE BOX)					DATE/TIME	INITIALS
	E-Mail Scan	Fax	US Mail (Certified)	Verbal	Other *(specify)*		
Commissioner's Office, Jensen Compliance Officer[1] *Comments:*	☐	☐	☐		☐		
CEO, State Operated Services[1] *Comments:*	☐	☐	☐		☐		
Director of Operations Support[1] *Comments:*	☐	☐	☐		☐		
MSHS-Cambridge Site Director[1] **(Not applicable for MSOCS)** *Comments:*	☐	☐	☐		☐		
MSOCS Director[1] **(Not applicable for MSHS-Camb)**	☐	☐	☐		☐		
***Attorney General**[1] *Comments:*	☐	N/A	☐		☐		

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