UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen; James Brinker and Darren Allen, as parents, guardians and next friends of Thomas M. Allbrink; Elizabeth Jacobs, as parent, guardian and next friend of Jason R. Jacobs; and others similarly situated,

Plaintiffs,

v.

Minnesota Department of Human Services, an agency of the State of Minnesota; Director, Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Clinical Director, the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Douglas Bratvold, individually, and as Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Scott TenNapel, individually and as Clinical Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; and State of Minnesota,

Defendants.

Civil No. 09-1775 (DWF/FLN)

ORDER

Margaret Ann Santos, Esq., Mark R. Azman, Esq., and Shamus P. O'Meara, Esq., O'Meara Leer Wagner & Kohl, PA, counsel for Plaintiffs.

Steven H. Alpert and Scott H. Ikeda, Assistant Attorneys General, Minnesota Attorney General's Office, counsel for State Defendants.

Samuel D. Orbovich, Esq., and Christopher A. Stafford, Esq., Fredrikson & Byron, PA, counsel for Defendant Scott TenNapel.

Before the Court is the *Court Monitor's Report to the Court: Recommended Revision to MSHS-Cambridge Restraint Policy* (Dec. 6, 2013, Doc. No. 256). The report is **APPROVED** and **ADOPTED**.

The Monitor recommends that a revised restraint policy replace Attachment A to the Settlement Agreement (Doc. No. 104-1). The Settlement Agreement's Attachment A set forth the prohibition on all restraints at MSHS-Cambridge, except for emergency use of manual restraint and "Velcro soft cuffs and fabric ankle straps."[1] The recommended revised policy eliminates the soft cuffs and ankle strap option and makes other changes. The Monitor also recommends special staff training on the revised policy.

The Department of Human Services responded positively to the draft of this report, acknowledging the need for revisions and providing proposed a new policy which meets the concerns of the Court Monitor. Plaintiffs also responded positively.

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[1] Attachment A was incorporated into the order approving the Settlement Agreement; like all court orders, it is not subject to unilateral revision by Defendants. Nevertheless, Defendants improperly revised and re-issued the policy twice since the approval of the Settlement Agreement.

- November 1, 2010. Procedure #3503. Effective December 2010. This is Attachment A to the Settlement Agreement (Doc. No. 104-1, filed June 23, 2011).
- March 7, 2013. Procedure #15868. Effective March 15, 2013.
- November 8, 2013. Procedure #15868. Effective November 12, 2013.

The revised policy, endorsed by the Court Monitor, incorporates the parties' agreement to eliminate the Velcro soft cuffs and fabric ankle straps exception, and thus establishes Cambridge as a facility entirely free from use of mechanical restraints. In addition, the new policy substantially reduces to fifteen minutes the time in which a person may be held in manual restraint in an emergency and requires an offer to release every two minutes. The time period for professional staff review of restraint use is shortened as is the time by which treatment program changes must be adopted when appropriate.

Upon consideration of the Monitor's Report and the entire record in this case, **IT IS HEREBY ORDERED:**

1. The revision to Attachment A, set forth in the attachment to this Order, is hereby **APPROVED** and **ADOPTED** by the Court and shall be implemented by Defendants.

2. All current and future staff be specially trained in the revisions to Attachment A, including staff at MSHS-Cambridge and its successor programs. For current staff, the training shall be completed within thirty (30) days of this Order. Defendants shall provide the Court Monitor with an advance written summary of the training curriculum and methods, for his approval. For the current staff, sign-in sheets showing that all staff have been trained shall be provided to the Court Monitor. The

training shall be in-person and didactic and shall not consist merely of a sign-off of receipt of the policy.

Dated: December 11, 2013

s/Donovan W. Frank
DONOVAN W. FRANK
United States District Judge

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