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Procedure Number: 3503

## CLIENT CARE

### THERAPEUTIC INTERVENTIONS AND EMERGENCY USE OF PERSONAL SAFETY TECHNIQUES

**SOS REFERENCE POLICY NUMBER:** 6260

#### **BACKGROUND:**

METO 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. METO prohibits the use of any aversive or deprivation procedures as interventions in a client's Individual Program Plan or equivalent treatment plan documentation.

#### **PURPOSE:**

Even within the framework of positive behavior support programming in the Treatment 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. METO 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 METO, will be as a safety measure when treatment has failed and an emergency results. The only type of emergency restraint permitted at METO is certain specified manual restraint and the use of Velcro soft cuffs and fabric ankle straps. METO 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 Treatment 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. METO 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:**

A. Client: An individual receiving treatment at METO.

- B. Responsible Supervisor: Home Supervisor, Work Supervisor, Administrator on Duty (AOD), or Lead Worker on Duty.
- C. 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.
- D. Therapeutic Interventions: A form of intervention which consists of early identification of potential emergencies; prevention of emergencies through verbal, non-verbal, and non-physical 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 Treatment Plan.
- E. Personal Safety Techniques (PST): Application of external physical control by employees to clients only when clients cause 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.
- F. Manual Restraint: “Manual restraint” means physical intervention intended to hold a client immobile or limit a person’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.
- G. Mechanical Restraint: “Mechanical restraint” means the use of a device to limit a person’s movement or hold a person immobile as an intervention precipitated by a person’s behavior. The only approved mechanical restraints at METO are Velcro soft cuffs and fabric ankle straps. The term does not apply to devices used to treat a person’s medical needs to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person’s Treatment Plan.
- H. 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.
- I. Expanded Interdisciplinary Team: Expanded interdisciplinary team means a team composed of: the client receiving treatment from METO; 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 person's Treatment 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.

- J. Treatment Plan: A plan developed by the Expanded 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 Expanded Interdisciplinary Team in creating treatment interventions that will effectively help the client get his or her needs met by alternate methods.
- K. Prone Restraint: "Prone restraint" means any restraint that places the individual in a face-down 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.
- L. Restraint means the use of manual, mechanical, prone, or chemical restraint.
- M. Chemical restraint is the administration of a drug or medication when it is used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement and is not a standard treatment or dosage for the resident's condition. Orders or prescriptions for the administration of medications to be used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement shall not be written as a standing order or on an as-needed basis (PRN).
- N. Seclusion means the placement of a person alone in a room from which egress is:
  - a. noncontingent on the person'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 person from leaving the room.
- O. Time out means removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the individual program plan for reduction or elimination. Room time out means removing a person from an ongoing activity to a room (either locked or unlocked).

## **RESPONSIBILITIES & PROCEDURES:**

- A. Assessments
  - 1. Development of the Treatment Plan: Following admission, the Designated Coordinator for the client's Expanded 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: METO RN's shall ensure that all METO 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 METO 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. 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, a 16 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. Semi-annually thereafter, 8 hours (4 hours in therapeutic intervention, including boundaries and negotiation, and 4 hours of training in personal safety techniques), with mandatory skill check-off and certification.
    - i. 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.
    - ii. Recommended SOS certified TI/PST instructor to student ratio for refresher training is 2 to 15.
    - iii. All training of employees in Therapeutic Intervention shall be conducted by SOS certified therapeutic intervention instructors.
    - iv. All employees shall complete a therapeutic intervention course at minimum annually and optimally semi-annually or more often if assigned by supervisor.
  - c. Staff are trained in early detection of escalation for a particular individual, through client specific training on their treatment 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 EIDT modifies the client's Treatment 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 Treatment 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 Treatment 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 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.

- e. Notify the RN and/or Lead Worker On Duty immediately.
- f. Notify the responsible supervisor immediately.
- g. Make sure a METO Form #31032 (Documentation for Implementation of Controlled Procedure) 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 METO Form #31032.
- 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 resident'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 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 evidenced 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).

1. 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 reinstate the restraint. Verbal threats alone are insufficient reason to reinstate 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.
- 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 restraint may last longer than 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 a consideration of the use of psychotropic medication to manage the client's mental health symptoms more effectively and minimize the need for further restraint to keep the individual safe (METO Procedure #3601).
- 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 METO form #31032.
- 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 except Velcro soft cuffs and fabric ankle straps may be used only when an emergency
  - 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 METO Form #31032. This form must be completed before the end of each person's shift.
  - b. A client Incident Report (see METO Procedure #3303) shall be completed if the client experienced any physical injury.
- 2. Nursing/Designee:
  - a. Review and complete designated nursing sections of METO Form #31032.
  - b. Ensure that the completed METO Form #31032 summarizes the opinions of the private vendor who was consulted.
  - c. Review and complete designated nursing section of METO client incident report and submit to supervisor/AOD/Lead Worker on Duty.
- 3. Supervisor/AOD/Lead Worker on Duty:
  - a. Review and complete designated supervisory sections of METO Form #31032.
  - b. Ensure that the completed METO Form #31032 summarizes the opinions of the private vendor who was consulted.
  - c. Ensure that the completed original of form #31032 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 (See METO Protocol #1402) if any staff experience an injury and deliver to Human Resources by the end of the shift.
  - e. Review and complete a client incident report if the client experienced any injury and route to the HIMS collection area before the end of the shift on which the injury occurred.

4. HIMS

- a. Scan form #31032 and send copies to the METO Director/Operations Manager, Facility Clinical Supervisor, and the client's treatment team. A reasonable effort must be made to submit it within 24 hours, but in no event later than the next business day.
- b. The completed METO form 31032 shall be submitted electronically, faxed or personally delivered 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
  - (1). Office of Health Facility Complaints;
  - (2). Ombudsman for Mental Health and Developmental Disabilities;
  - (3). DHS Licensing;
  - (4). DHS Internal Reviewer;
  - (5). Client's family and/or legal representative;
  - (6). Case manager;
  - (7). Plaintiffs' counsel.
- c. **Within 14 calendar days** after the use of restraint, members of the EIDT must confer to discuss the following (HIMS has 7 days to submit to county case manager, and county case manager has 7 days after receiving the report to confer):
  - 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 or 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.
- d. The Designated Coordinator will document any recommendations the EIDT makes in regards to 1-6 above on METO Form #31025 and submit the completed form to HIMS. The HIMS department shall then forward the original to the Operations Center for filing in the client's permanent medical record and to the Behavior Management Review Committee.
- e. The Designated Coordinator will identify in the client's Treatment Plan any recommendations the EIDT makes in regards to 1-6 above.

- f. Submit a copy of the Emergency Use of Controlled Procedure Report to the BMRC, the DHS internal reviewer, and as otherwise required by law within five working days after the EIDT review of the emergency use of restraint.
  - g. 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 Treatment Plan within 15 calendar days after the EIDT review above. The Designated Coordinator shall document the decisions of the EIDT 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.
  - h. 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 EIDT, METO Director, facility Clinical Supervisor or designee, and the DHS internal reviewer to determine if any modifications or adjustments to the treatment plan would be warranted.
5. Behavior Management Review Committee (BMRC)  
The BMRC reviews completed METO Forms #31025 and #31032 at its regularly scheduled meeting and identifies any concerns they might have regarding the use of restraint and document them in the BMRC 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 METO Administration. Completed CARE information will be submitted to the METO Director and assigned CARE review team for review and follow up with the respective METO treatment teams, SOS Therapeutic Intervention instructors, or the internal Behavior Management 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 (or Facility Operations Manager), facility Clinical Supervisor, and DHS [Internal Reviewer] monthly.

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

**REFERENCES:**

A. State Operated Services Policy 6260, Therapeutic Intervention

**CANCELLATIONS:** This procedure supersedes METO Procedure #3503 dated 2/2009.

**REVIEWER:** FACILITY Director/ Facility Operations Manager

**AUTHENTICATION SIGNATURES:**

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**Facility Director/ Facility Operations Manager**

SETTLEMENT AGREEMENT ATTACHMENT A

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