Emergency Use of Manual Restraints Allowed Sample Policy

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Program Name: ________________________________________________________________

I. Policy

It is the policy of this DHS licensed program to promote the rights of children served by this program and to protect their health and safety during the emergency use of manual restraints.

“Emergency use of manual restraint” means using a manual restraint when a child poses an imminent risk of physical harm to self or others and it is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a child’s refusal to receive or participate in treatment or programming on their own do not constitute an emergency.

II. Positive support strategies and techniques required

The following positive support strategies and techniques must be used to attempt to de-escalate a child’s behavior before it poses an imminent risk of physical harm to self or others:

[Insert a description of the positive support strategies and techniques to be used by the program.]

- Ensure that each child is provided with a positive model of acceptable behavior;
- Be tailored to the developmental level of the children that the center is licensed to serve;
- Redirect children and groups away from problems and toward constructive activity in order to reduce conflict;
- Teach children how to use acceptable alternatives to problem behavior to reduce conflict;
- Protect the safety of children and staff persons; and
- Provide immediate and directly related consequences for a child’s unacceptable behavior.

Other examples that a program could use include:

- Reinforce appropriate behavior
- Offer choices to the person, including activities that are relaxing and enjoyable;
- Use positive verbal guidance and feedback;
- Actively listen to a child and validate their feelings;
- Speak calmly with reassuring words, consider volume, tone, and non-verbal communication;
- Simplify a task or routine, or discontinue until the child is calm,
III. Permitted actions and procedures

Use of the following instructional techniques and intervention procedures on an intermittent or continuous basis are permitted by this program. When used on a continuous basis, they must be addressed in the Individual Child Care Program Plan.

A. Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the child and may be used to:
   1. Calm or comfort a child by holding the child with no resistance;
   2. Protect a child known to be at risk of injury due to frequent falls as a result of a medical condition;
   3. Facilitate the child’s completion of a task or response when the child does not resist or the child’s resistance is minimal in intensity and duration;
   4. Block or redirect a child’s limbs or body without holding the child or limiting the child’s movement to interrupt the child’s behavior that may result in injury to self or others, with less than 60 seconds of physical contact by staff;
   5. Redirect a child’s behavior when the behavior does not pose a serious threat to the child or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

B. Restraint may be used as an intervention procedure to:
   1. Allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a child necessary to promote healing or recovery from an acute, meaning short-term, medical condition;
   2. Assist in the safe evacuation or redirection of a child in the event of an emergency where the child is at imminent risk of harm;
   3. Position a child with physical disabilities as specified in the child’s individual child care program plan.
   4. Any use of manual restraint as allowed in this paragraph [Section B] must comply with the restrictions identified in [Section A].

C. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not constitute the use of mechanical restraint.

IV. Prohibited Procedures

Use of the following procedures as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience, is prohibited by this program:
   1. Chemical restraint;
   2. Mechanical restraint;
   3. Manual restraint;
   4. Time out;
   5. Seclusion; or
   6. Any aversive or deprivation procedure.
Manual Restraints Allowed in Emergencies

A. This program allows the following manual restraint procedures to be used on an emergency basis when a child’s conduct poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety:

- Physical escort;
- One staff person arm restraint in standing position; or
- The attached list of the allowed manual restraints that includes a description of those that trained staff are allowed to use, and instructions for the safe and correct implementation of those procedures.

B. The program will not allow the use of a manual restraint procedure with a child when it has been determined by the child’s physician or mental health provider to be medically or psychologically contraindicated. This program will complete an assessment of whether the allowed procedures are contraindicated for each child receiving services.

VI. Conditions for Emergency Use of Manual Restraint

A. Emergency use of manual restraint must meet the following conditions:
   1. Immediate intervention must be needed to protect the child or others from imminent risk of physical harm;
   2. The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety; and
   3. The manual restraint must end when the threat of harm ends.

B. The following conditions are not conditions for emergency use of manual restraint:
   1. The child is engaging in property destruction that does not cause imminent risk of physical harm;
   2. The child is engaging in verbal aggression with staff or others; or
   3. A child’s refusal to receive or participate in treatment or programming.

VII. Restrictions When Implementing Emergency Use of Manual Restraint

Emergency use of manual restraint must not:

1. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury;
2. Be implemented in a manner that is medically or psychologically contraindicated for a child;
3. Restrict a child’s normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing;
4. Deny a child visitation or ordinary contact with a legal representative, or next of kin;
5. Be used as a substitute for adequate staffing for the convenience of staff, as punishment, or as a consequence if the child refuses to participate in the treatment or services provided by this program;
6. Use prone restraint, meaning use of manual restraint that places a child in a face-down position. It does not include brief physical holding of a child who, during an emergency use of manual restraint, rolls into a prone position, and the child is restored to a standing, sitting, or side-lying position as quickly as possible;
7. Apply back or chest pressure while a child is in a prone position, supine (meaning a face-up) position, or side-lying position,
8. Be implemented in a manner that is contraindicated for any of the child’s known medical or psychological limitations.

VIII. Monitoring Emergency Use of Manual Restraint

A. The program must monitor a child’s health and safety during an emergency use of a manual restraint. The purpose of the monitoring is to ensure the following:
   1. Only manual restraints allowed in this policy are implemented;
   2. Manual restraints that have been determined to be contraindicated for a child are not implemented with that child;
   3. Allowed manual restraints are implemented only by staff trained in their use;
   4. The restraint is being implemented properly as required; and
   5. The mental, physical, and emotional condition of the child being manually restrained is being assessed, and intervention is provided when necessary, to maintain the child’s health and safety and prevent injury to the child, staff, or others involved.

A. When possible, a staff person who is not implementing the emergency use of a manual restraint must monitor the procedure.

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

IX. Reporting Emergency Use of Manual Restraint

A. Within 24 hours of an emergency use of manual restraint, the child’s parents and any legal representative, case manager, etc., must receive verbal notification of the occurrence.

When the emergency use of manual restraint involves more than one child receiving services, the incident report made to the child’s parents and any legal representative, case manager, etc., must not disclose personally identifiable information about any other child unless the program has the consent of the person.

B. Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing the following information about the emergency use to the program’s designated coordinator:
   1. The names of staff and the child involved in the incident leading up to the emergency use of a manual restraint;
   2. A description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of a manual restraint;
   3. A description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the emergency use of a manual restraint was implemented. This
description must identify when, how, and how long the alternative measures were attempted before the manual restraint was implemented;
4. A description of the mental, physical, and emotional condition of the child who was manually restrained, leading up to, during, and following the manual restraint;
5. A description of the mental, physical, and emotional condition of other persons involved leading up to, during, and following the manual restraint;
6. Whether there was any injury to the child who was restrained before, or as a result of, the use of a manual restraint;
7. Whether there was any injury to other persons, including staff, before, or as a result of, the use of a manual restraint; and
8. Whether following the incident there was a debriefing with staff and, if not contraindicated, the child who was restrained and other persons involved in or who witnessed the restraint. Include the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned.

C. A copy of this report must be maintained in the child’s record. The record must be uniform and legible.

D. Each single incident of emergency use of a manual restraint must be reported separately. A single incident is defined as meeting these conditions:
1. After implementing the manual restraint, staff attempt to release the child at the moment staff believe the child’s conduct no longer poses an imminent risk of physical harm to self or others, and less restrictive strategies can be implemented to maintain safety;
2. Upon the attempt to release the restraint, the child’s behavior immediately re-escalates; and,
3. Staff must immediately re-implement the manual restraint in order to maintain safety.

X. Internal Review of Emergency Use of Manual Restraint

A. Within five business days after the date of the emergency use of a manual restraint, the program must complete and document an internal review of the report prepared by the staff member who implemented the emergency procedure.

B. The internal review must include an evaluation as to whether:
1. The child’s service and support strategies need to be revised;
2. Related policies and procedures were followed;
3. The policies and procedures were adequate;
4. There is need for additional staff training;
5. The reported event is similar to past events with the child, staff, or the services involved; and
6. There is a need for corrective action by the program to protect the health and safety of children.

C. Based on the results of the internal review, the program must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the program.

D. The corrective action plan, if any, must be implemented within 30 days of the completed internal review.
E. The program has identified the following person or position responsible for conducting the internal review and for ensuring that corrective action is taken, when determined necessary:

[Insert the name and/or position title of the responsible person who will conduct internal reviews.]

XI. Expanded Support Team Review of Emergency Use of Manual Restraint

A. Within five working days after the completion of the internal review, the program must consult with the child’s parents and other staff persons and professionals to:
   1. Discuss the incident to:
      a. Define the antecedent or event that caused the behavior resulting in the manual restraint; and
      b. Identify the perceived function the behavior served.
   2. Determine whether the child’s Individual Child Care Program Plan needs to be revised to:
      a. Positively and effectively help the child maintain stability; and,
      b. Reduce or eliminate future occurrences of manual restraint.

B. The program must maintain a written summary of the expanded support team’s discussion and decisions in the child’s record.

C. The program has identified this person or position to conduct the expanded support team review and ensure that the child’s Individual Child Care Program Plan is revised as necessary.

[Insert the name and/or position title of the responsible person who will revise the Individual Child Care Program Plan.]

XII. External Review and Reporting of Emergency Use of Manual Restraint

Within five working days after the completion of the expanded support team review, the program must submit the following to the Department of Human Services and the Office of the Ombudsman for Mental Health and Developmental Disabilities using the online Behavior Intervention Reporting Form (BIRF DHS-5148):

1. A report of the emergency use of a manual restraint;
2. The internal review and corrective action plan; and
3. A written summary of the expanded support team review.
XIII. Staff Training

Before staff can implement manual restraints on an emergency basis the program must provide this required training:

A. The program must provide staff with orientation and annual training as required.
   1. Before having unsupervised direct contact with persons served by the program, the program must provide instruction on prohibited procedures that address the following:
      a. What constitutes the use of restraint, time out, seclusion, and chemical restraint;
      b. Staff responsibilities related to ensuring prohibited procedures are not used;
      c. Why such prohibited procedures are not effective for reducing or eliminating symptoms or undesired behavior;
      d. Why prohibited procedures are not safe; and
      e. The safe and correct use of manual restraint on an emergency basis.
   2. Within 60 days of hire, the new staff must receive instruction on the following topics:
      a. Alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others;
      b. De-escalation methods, positive support strategies, and ways to avoid power struggles;
      c. Simulated experiences of administering and receiving manual restraint procedures allowed by the program on an emergency basis;
      d. How to properly identify thresholds for implementing and ceasing restrictive procedures;
      e. How to recognize, monitor, and respond to the child’s physical signs of distress, including positional asphyxia;
      f. The physiological and psychological impact on the child and staff when restrictive procedures are used;
      g. The communicative intent of behaviors; and
      h. Relationship building.

B. If the new staff person received training on these topics in the 12 months prior to being hired, this may count toward the requirement.

C. The program must maintain documentation of the training received and of each staff person's competency in each staff person's personnel record.

Policy reviewed and authorized by:

Signature: ___________________________ Print name & title: ________________________________

Date of last policy review: _______________ Date of last policy revision__________________

Legal Authority: MS §§ 245D.06, subd. 5 to subd, 8; 245D.061