EMERGENCY INTERVENTION PROCEDURES

2013 California Code
Health and Safety Code - HSC
Division 1.5. use of seclusion and behavioral restraints in facilities
1180.4

Emergency Intervention Plan
The facility emergency intervention plan is designed to provide staff with the techniques and training to intervene and de-escalate a client experiencing a behavioral crisis. The purpose of the intervention is designed to protect the client, as well as any other individuals nearby who's physical safety, is compromised. The techniques may be employed in the facility as well as public settings. Criteria to implement the plan include danger to self, danger to others and or the violation of the rights of others. The plan is rooted in the idea that techniques are employed in the least restrictive manner.

Emergency Intervention Procedures are designed to de-escalate a client without harm or injury. Emergency procedures are not specified in the clients IPP or behavior plan prepared by the behaviorist. The Emergency Plan is a separate and unique document for the facility that justifies and application of seclusion and restraint as a last resort.

Restraints are different from manual prompts. Restraints are to be used only when there is an emergency event and are never part of the client's behavior plan. Manual prompts are utilized as part of the emergency intervention and may also be part of the client's IPP or behavior plan.

An emergency is defined as a behavior that is a clear and present danger to self or others. The intensity and potential for harm caused by the behavior require the temporary application of manual restraint and sections. The Emergency Intervention Plan outlines the methods to apply these techniques in a way that respects the dignity of the client and protects their civil and personal rights.

Advanced Directive (see Advanced Directive attachment)
Each resident shall have an advanced directive that specifies preferred emergency intervention techniques to be used in de-escalation including seclusion and restraint. (see Advanced Healthcare Directive Attachment). The Advanced Healthcare Directive as it pertains to emergency intervention applies to an emergency event that may happen at the residence or health care setting such as a psychiatric hospital. If the resident is hospitalized, the advanced directive will accompany the resident to the hospital. The licensee shall honor the client's advance directive unless it violates statue **or regulation, or it impinges upon the health or safety of the client or another person.**

Early Warning Signs and History
Critical to emergency intervention and de-escalation is the early identification of warning signs, triggers, and precipitants that cause a person to escalate and become aggressive to self or others. The foundation of successful de-escalation of aggression is the identification of early signs that occur before the behavioral crisis. Each client is different and signals these early signs differently. Historical information regarding past incidents of aggression is pivotal in discovering what early signs are unique for each client. The licensee will gather information on each client with a potential for aggressive behavior from past data. Historical information is culled from medical and psychiatric reports, former residential placement, day programs as well as family.

Residents with a known history of aggression will also be carefully assessed to determine if there are any medical conditions or physical disabilities or limitations that would place the person at greater risk during restraint and seclusion. Any history of trauma including sexual or physical abuse will be assessed and specified in the client emergency intervention plan.

Staff Qualifications
ABC Residential contracts with a behavior consultant. The consultant provides training in an emergency intervention based on PART Professional Assault Response Training.

PART is designed to assist staff with a means of identification and appropriate response to potentially assaultive/aggressive situations. PART focuses on prevention by teaching the concept that all behavior is communication. If staff can identify and respond to behavior, they may be able to prevent escalation to a potentially dangerous situation. Hands-on techniques are also trained to keep everyone safe when preventative measures are not successful, and dangerous behaviors do occur.

Only staff who receive training from the Behavior Consultant assigned to the facility will be considered qualified to implement emergency intervention techniques. Job titles of staff who can implement emergency intervention techniques include Direct Support Professional and House Manager.

Manual Prompts
Restraints are to be used only when there is an emergency event and are never part of the client's behavior plan. Manual prompts are NOT the same as restraints. Manual prompts may be detailed as part of the client's behavior plan. In the context of Emergency, Intervention manual may be used as a technique to restrain an individual against their will and choice.

Manual prompts are never considered aversive or illegal unless the client is verbally or physically resisting such prompting. If the client requires a great deal of manual prompting to accomplish a task, staff will provide that much prompting to de-escalate the behavior. Manual prompt becomes restraint when the client states or physically refuses to cooperate, and the behavior crisis escalates. At this point manual prompt become restraint. Restraints are considered aversive and illegal. Restraint is allowed

only the behavior manifested by the client is a danger to sell others or compromise the racists of others. Without these conditions, there is no justification for restraint. Manual prompts occur in a gradual hierarchy that includes:

1. Gesture Prompt — signals are given to the client as a reminder to do something, such as pointing to the dishwasher or the bathroom.

2. Verbal Prompt — a direct verbal instruction is informing the client what you wish for them to do.

3. Tactile Prompt — a physical touch, such as putting your hand on their back to signal the client to move in that direction while also using the verbal prompt to inform them of your intention.

4. Physical Prompt — giving physical assistance and guidance to get the client started on something you are asking them to do when they do not respond and do not resist.

5. Guided Performance — providing complete physical assistance in helping the client accomplish a task that they don't know how to do or are not motivated to do themselves.

6. Restraint — providing the client with physical prompts they do not wish to receive and are resisting and escalating as a result of your efforts.

Rights and Prompts

Prompts are normally used on a regular basis with most clients to achieve success in independent living skills and reduction of undesirable behaviors. Restraints are never used unless part of the emergency intervention plan.

Clients are free individuals who have all the same rights and privileges of all other individuals unless they are conserved. Conservatorship of a client rights are controlled by the conservator. A conservatorship never justifies abusive practices that violate the right to be free from pain. Social norms of courtesy and respect are always present in the implementation of manual prompts and restraint. Restrain always occurs in a manner that avoids placing the client or anyone else in the vicinity of danger.

The primary goal of emergency intervention and possibly restraint is to assist the client to regain control and independence. The goal is never to punish or withhold rights of an individual who is already suffering from a behavioral crisis.

Physical Contact and Intervention

Staff will avoid using physical intervention unless there is a clear and present danger of physical injury. Physical altercations are dangerous to both the client and staff. Staff

will seek the position of defense when involved in a violent episode. The position of defense is the position of advantage. Staff should never be in a posture of attack toward the client.

Staff should always use their weight and leverage against the client's strength. Avoid efforts to overpower or out-muscle the client. When there is a choice, always grasp the client by the clothing rather than the flesh. Clothing affords a better grip.
Grasp the limbs at points just above the joints. This affords better leverage and minimizes the risk of joint injury.

When containing clients against the wall or on the floor, hold them with their face to the surface. This position allows the client some mobility. The goal of physical intervention procedures is to help the client regain self- control, not impose rigid external control.

Staff should always use space to their advantage. Try to minimize the space available to the client and maximize the space available to the staff. Teamwork is an advantage. The person with the best contact with the client at the moment should be allowed to lead the team. All should move at once when the signal is given.

Once contact has been made, don't let go until all agree that it is safe. If forced to let go, warn other team members. Assemble enough team members to do the job effectively and safely and keep other staff out of the way. Five persons are the maximum that can work together effectively. Others can be used for crowd control, moving furniture, opening doors, etc. Staff should not attempt to intervene unless there are not enough trained and capable team members.

More than One Client

If more than one client is suffering from a behavioral crisis and requires intervention best practice is to separate as quickly as possible the two clients. Effort should be made to move each client to a separate low key stimulus environment. Often events with more than one client are a physical fight in which one client is the aggressor and the other a victim. A triage sort should be employed to assign more staff to the client who is experiencing a more severe crisis. More staff should be called to assist in any complex crisis event involving more than one client. If more staff are not available and is it is not possible to successfully implement de-escalation techniques 911 or the psychiatric mobile response team should be contacted. 911 should only be called if he client is a clear and present danger to him or herself.

Client Types of Aggression and Assault

There are three basic types of assaultive/aggressive clients that may be encountered in any given setting. Anti-social personalities are not in included in this scheme. Anti-social or sociopathic individual engage in aggression as a calculation to intentionally

harm others. Anti-social types should not be in any public programs where they have access to innocent individuals and should be referred out. The three types are:

Frightened Client: A person who is extremely frightened of being killed or hurt within the next few minutes.

The Frenzied Client: A violently frustrated person who is ready to destroy anything he/she can put his/her hands on.

The Client Having A Temper Tantrum: A person who is upset and ready to use violence to get what he/she wants.

Table 1 below describes the characteristics of each of the above types of assaultive clients, their symptoms, and the recommended approach to use when confronting each type of individual in an escalation cycle.

Table 1

The Three Types of Assaultive Clients

Behavior	Symptom	Recommendation
Fright/Fear Extremely frightened, scared of being hurt or killed in the very near future.	Pale skin color Defensive posture Rapid shallow breathing yes wide open, pupils dilated Defensive gestures	**Reduce Perceived Threat** Keep voice calm and reassuring Open posture, 8-12 feet distance, palms up gestures Reassuring, protective words
Frenzied Violent frustrated; may destroy anything within reach.	Attack posture Heavy rapid breathing Eyes narrowed, focused Threatening gestures Flushed skin tone (pink)	**Communicate Control** Quiet, controlled voice Command posture Stand directly in front just out of reach Palm down gestrues Firm words Set limits
Temper Tantrum (uproar) Very upset and ready to use violence to get own way in the situation.	Diffuse agitation Usually follows a pattern Produces confusion “Gimme” issue Object or person oriented violence	**Avoid Playing Games** Keep distance, disapproving voice Closed posture Stand at eye level; face client No gestures Withdraw eye contact Words: Demand calm before addressing the issue

Assault follows a predictable pattern of excitation as noted in the graph below. This pattern has five distinct phases (see Figure 1).

The Assault Cycle

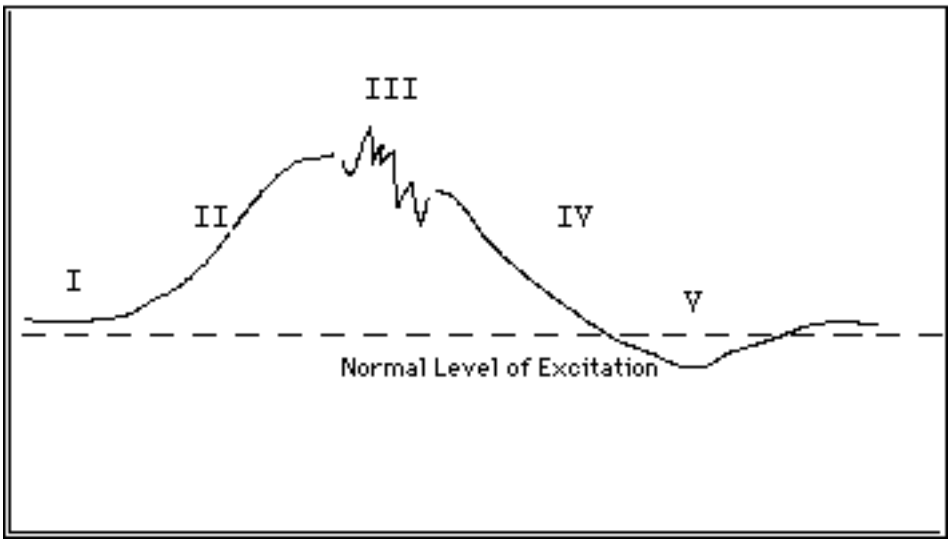


Figure 1

I. The Triggering Phase
II. The Escalation Phase
III. The Crisis Phase
IV. The Recovery Phase
V. Post-Crisis Phase

The Responsibility Continuum

External Factors are Responsible For Assault <——————————————> Internal Factors are Responsible for Assault

The goal of de-escalation is to address the crisis in the first phase. Staff must be trained in identifying the early signs of an oncoming episode. The guidelines for action on the various phases of the assault cycle are as follows:

Cycle of Escalation
All assault crisis paradigms recognize a predictable cycle that moves through the following sequence:

Phase I: Triggering or Stimulus Phase
There can be many environmental triggers or biological states that disrupt the client's normal state of being. Possible antecedents in the environment may include noise, temperature, disruption in routine, texture of clothing, the presence of people, or demand to engage in a task.

Biological antecedents may include, headache, hunger, fatigue, gastrointestinal distress, toothache or other physical states. A client in this condition can usually be diverted to another task or activity that will interrupt the escalation into a full crisis episode. Hence diversion tactics are recommended to a less demanding situation temporarily. Try to get the client away from the current situation.

Phase II: Escalation Phase
Agitation anxiety and irritability are often present at this stage and may be evidence of pacing, scanning and or a tightening of the body posture. Verbal behaviors at this phase may include repetitive questions, talking loudly and possibly complaints.

A client in this stage will usually give definite signs of the sources of the agitation. Diverting the client at this point may itself cause an escalation and hence is not recommended. The problem-solving approach is recommended attempting to remove the source of the agitation.

Phase III: Crisis Phase
It is in the crisis phase when the client's behavior presents a clear threat to self or others and may require physical intervention. The least restrictive method is to geographically contain the client in one area of the facility and move all other clients to another area. If this is not possible, staff should move the client as far away as possible to a safe area away from other clients. As the client's behavior escalates more restrictive methods are used to protect the acting-out client as well as others The hierarchy of restrictive approaches is listed below:

Crisis Communication: The least restrictive method is to use verbal mediation and reassurance that you will help the client resolve the problem. This step will continue with all other steps which follow until the problem has been resolved. Staff must communicate confidence that the problem will be resolved and that the client is safe. Staff will also firmly communicate that violent behavior is not appropriate and is not allowed.

Geographical Containment: Geographical containment is used if the verbal communication does not resolve the site. The staff places themselves between the client and everyone else and between the exit and the client without any physical intervention. Verbal mediation and reassurance continue to be used at this stage to halt the escalating behavior become ao a more serious episode.

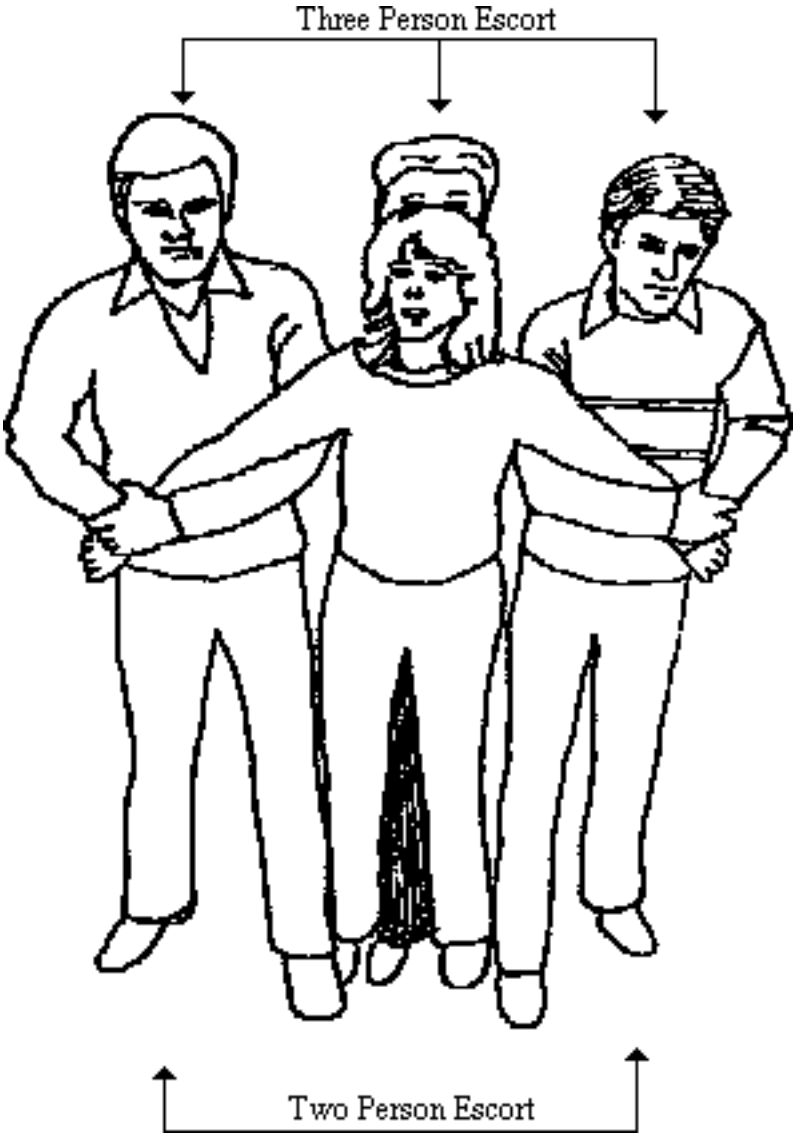
One Man, Two Man, or Three Man Escort: This procedure consists of one or more staff members physically removing and escorting the client to a safe area. For a One Man procedure, the staff must get behind the client, grab the shirt/blouse in the middle of the back and twist to secure a good grip, grab the pant belt area with the other hand, push the upper torso forward and steer with the mid-drift portion while walking forward to a safe area.

A **Two Man Escort** consists of one staff member on each side of the client. Each staff member is to place their arms under the client's arm, securing the shoulder, while holding the client's arm just above the elbow with the other hand, hugging it close to their body.

The Three Man Escort is essentially utilizing both of the above procedures consecutively.

Physical Containment: This is where the client is physically held against the nearest wall, facing it, until calm. The holds are again identical to the above procedures. If possible, before attempting any restraints to the wall or floor, staff should attempt to go to the nearest couch and sit with the person while maintaining the same holds with the additional move of placing your leg over their legs from both sides to prevent flailing and kicking. This is particularly important for a client with tracheotomies since pushing against the wall or floor could obstruct their breathing.

Two Man, or Three Man Restraint: This procedure consists of physically laying the client flat on the floor face down, and holding them until calm. Using the same holds, the staff is to place their legs in front of the client and move forward, breaking the fall by stopping with their knee, then proceeding to lay flat on the ground; (see figure below).



The **One Man Restraint** is never recommended. Staff should at least have two if not three people to attempt prone containment, especially if the client is larger than the staff. When staff is in a position where they cannot get away, the staff is to deflect the attack, move around them and attempt to get help from another staff. Make sure to keep your eyes and focus on the assaultive client and not let them get to other clients standing by. Instruct any other clients to leave the area and continue calling for help from other staff.

Visual Checks

Whenever manual restraint is required staff will continuously make a visual check to ensure, only the techniques as specified in this emergency plan are utilized. Any staff the either participate in, approve or provide visual checks of the manual restraint or seclusion will have a minimum of sixteen hours of emergency intervention training and be certified for having succsessfully completed the training.

Time Limits
No Manual restraint or seclusion will be employed for more than 15 consecutive minutes unless the licensee complies with Section 85322(e)(6);.

Unless discontinued sooner, at 15 consecutive minutes after the initiation of a manual restraint or seclusion, staff shall discontinue the manual restraint or seclusion.

The only exception to the 15-minute limitation above shall be when there is a continued need to protect the immediate health and safety of the client or others from risk of imminent serious physical harm, and the certified administrator obtains concurrent approval for every exception.

The administrator's approval shall be documented in the client record within 24 hours and also include an explanation of why it was necessary for the manual restraint or seclusion to go over 15 minutes, including a description of the client's imminently dangerous behavior.

The certified administrator mentioned in Section 85322(e)(6)(A)1. above
shall not be a participant in the manual restraint.

Emergency Intervention are Not Behavior Intervention Strategies
Do not attempt to use any of these procedures as intervention strategies to teach clients new skills. These are **Emergency Procedures Only.** Clients in the midst of a behavior crisis are not capable of learning conflict resolution or other coping skills. Learning only occurs in when the client conflicts free state.

When employing physical restraint only the use of necessary force is used. As the client becomes calm the staff should you relax their physical grip? The staff should always continue to reassure and speak to the client using resource and empathy. The amplitude and emotions communicate in the client's voice is a good indicator of stress. If the client continues to shows signs of distress it may be too early let go. Staff should loosen their loosen their only when it is clear through verbal and physical behavior that the client is no longer dangerous to self or others.

Post Crisis - Reintegration
When the client is no longer in crisis and has returned to their baseline level of functioning the goal is to reintegrate the client into their routine. This is best achieved by adopting a non judgemental attitude and making available the clients preferred activities.

Documentation
Whenever restraint is utilized staff must complete SIR and forward copies to the Regional Center and Community Care Licensing as well as APS if appropriate. Restraint is a violation of the client's rights and must be reported with a follow-up to determine if the procedure was justified and how to prevent the behavior crisis from happening again.

Monthly Log
A monthly log will be maintained with the name of each client for which manual restrain was used. The date and time of the manual restrainnt or seclusion will be recorded along with the time duration of the restraint or seclusion. The names of all staff who participated in the restraint and seclusion will be included in the log.

The log will specify the outcome of the emergency intervention including injury and death. If an injury did occur the entry will indicate if the injury is serious as defined by Health and Safety Code 1180.5 (b)

The serious injury" means a significant impairment of the physical condition such ass determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs.

Manual Restraint or Seclusion Review
The administrator or the administrator's designee shall conduct a clinical and quality review by conducting a debriefing meeting as soon as possible or within 24 hours of the manual restraint incident. The meeting shall include:

The client (participation of the client is voluntary).
The staff involved in the incident if reasonably available.
A client representative if available and requested by the client m by Health and Safety Code section 1`180.5

Criteria for Modification or Termination of Emergency Plan
If it is determined through implementation that the existing plan is not relevant or effective in addressing the aggressive incident, then the emergency plan will be reviewed. A regular review of SIR incidents may reveal a pattern that suggests that certain elements of the plan may need to be revised. For example, it may be determined that some types of prompts are more or less effective than others. This information is invaluable in making modifications in the future.

Criteria for Assessing Resources to Meet Needs of Client
If the Emergency Plan has been implemented with a particular client and found not to be effective the facility may not have the resources to meet the needs of that client.

Criteria For Assess Emergency Services
Emergency intervention to assist staff in an emergency intervention is provided through LAPD and or Los Angeles County Department of Mental Health.

If the client is acting in an aggressive dangerous manner and the Emergency Intervention is not successful in the de-escalation the client, and you and your client's

safety is threatened 911, and 5150 steps should be taken. Los Angeles County Department of Mental Health has available a Psychiatric Mobile Response Team. The team consists of a law enforcement officer and mental health clinician. The team can assist with the intervention as well as imitate a 5150 hold.

LA County Emergency Outreach
Emergency Outreach Bureau
550 S. Vermont Ave
2nd floor Los Angeles, CA 90020
213.738.4924

http://file.lacounty.gov/SDSInter/dmh/186287_EOBBrochureRev082011.pdf

Expected Outcome
The expected outcome of the emergency intervention is to de-escalate the resident to a psychological and physical state that existed before the crisis. Operationally this means the resident is no longer experiencing a behavior crisis and no longer considered a danger to self or others.