



## EMERGENCY USE OF MANUAL RESTRAINTS POLICY

**Program Name:** Robland HHC

### I. Policy

It is the policy of this DHS licensed provider Robland HHC to promote the rights of persons 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 person 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 person’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

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

#### Positive Support Strategies

- Staff should identify early warning signs that indicate that the individual is becoming agitated.
- Staff should become aware of their own agitation and emotions, and strive to maintain a calm presence.
- Staff should be mindful of the communication that they are using with the person, and that they are using verbal and non-verbal communication that matches the style and needs of the consumer. Generally, the staff should use a slow, soft tone of voice with low volume.
- Staff should approach the situation with the positive attitude of helping an individual who is having a difficult time.
- Staff should attempt to eliminate or alter components of the physical and social environment that may be contributing to the person’s agitation, such as noise, lighting, heat, and other people.
- Staff should listen to the concerns of the individual who is agitated.
- Staff should help the individual to identify the problems that the individual is experiencing stress with, and talk about possible solutions that may work for the individual.
- Staff should redirect the individual to a conversation that would change the individual’s focus.
- Staff should suggest activities that would be calming for the individual and that would create a new focus, such as listening to music, playing a game, sensory activities, going for a walk, or assembling a puzzle.
- Staff should scan the room and eliminate objects that can be used to injure themselves or others.
- Staff should follow individualized strategies in a person’s coordinated service and support plan and coordinated service and support plan addendum.

B. Robland HHC will develop a positive support transition plan on the forms and in manner prescribed by the Commissioner and within the required timelines for each person served when required in order to:

1. eliminate the use of prohibited procedures as identified in section III of this policy;
2. avoid the emergency use of manual restraint as identified in section I of this policy;
3. prevent the person from physically harming self or others; or
4. phase out any existing plans for the emergency or programmatic use of aversive or deprivation procedures prohibited.

### **III. Permitted Actions and Procedures**

Use of the following instructional techniques and intervention procedures used on an intermittent or continuous basis are permitted by this program. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum.

A. Physical contact or instructional techniques must be use the least restrictive alternative possible to meet the needs of the person and may be used to:

1. calm or comfort a person by holding that persons with no resistance from that person;
2. protect a person known to be at risk or injury due to frequent falls as a result of a medical condition;
3. facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; or
4. to block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others with less than sixty (60) seconds of physical contact by staff; or
5. To redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than sixty (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 person necessary to promote healing or recovery from an acute, meaning short-term, medical condition; or
2. assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.
3. Position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.
4. Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in subdivision 6, paragraph (b) (section 7 of this policy).

5. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a license health professional to treat a diagnosed medical condition do not in and of themselves 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

#### **V. Manual Restraints Not Allowed in Emergencies**

- A. Robland HHC does not allow the emergency use of manual restraint. The following alternative measures must be used by staff to achieve safety when a person's poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety:

**Alternative measures staff must use to maintain safety**

- Continue to utilize the positive support strategies.
- Continue to follow individualized strategies in a person's coordinated service and support plan and coordinated service and support plan addendum.
- Ask the person and/or others if they would like to move to another area where they may feel safer or calmer.
- Remove objects from the person's immediate environment that they may use to harm self or others.
- Call 911 for law enforcement assistance if the alternative measures listed above are ineffective to order to achieve safety for the person and/or others. While waiting for law enforcement to arrive staff will continue the alternative measures listed above if doing so does not pose a risk of harm to the person and/or others.
- Refer to the attached list of alternative measures that includes a description of each person of the alternative measures trained staff are allowed to use and instructions for the safe and correct implementation of those alternative measures.

- B. Robland HHC will not allow the use of a manual restraint procedure with a person when it has been determined by the person'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 person receiving services as part of the service planning required under section 245D.071, subdivision 2, for recipients of basic support services; or the assessment and initial service planning required under section 245D.071, subdivision 3, for recipients of intensive support 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 person 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, on their own, are not conditions for emergency use of manual restraint:
1. the person is engaging in property destruction that does not cause imminent risk of physical harm;
  2. the person is engaging in verbal aggression with staff or others; or
  3. a person'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; as defined in section 626.556, subdivision 2
2. be implemented with an adult in a manner that constitutes abuse or neglect; as defined in section 626.5572, subdivision 2 to 17
3. be implemented in a manner that violates a person's rights and protection; identified in section 245D.04
4. be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.
5. restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing; or any protection required by state licensing standards or federal regulations governing the program.
6. restrict a person's normal access to any protection required by state licensing standards and federal regulations governing this program;
7. deny a person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;
8. be used for the convenience of staff, as punishment, as a substitute for adequate staffing or as a consequence if the person refuses to participate in the treatment or services provided by this program;
9. use prone restraint. For purposes of this section, "Prone restraint" means use of manual restraint that places a person in a face-down position. Prone restraint does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible; or

10. Apply back or chest pressure while a person is in a prone position as identified in clause (7), supine position, or side-lying position.

### **VIII. Monitoring Emergency Use of Manual Restraint**

- A. Robland HHC must monitor a person'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 person are not implemented with that person;
  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 person who is being manually restrained is being assessed and intervention is provided when necessary to maintain the person's health and safety and prevent injury to the person, staff involved, or others involved.
- B. 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 legal representative and the case manager must receive verbal notification of the occurrence as required under the incident response and reporting requirements in section 245D.06, subdivision 1.

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

- B. Within 3 calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the program's designated coordinator the following information about the emergency use:
  1. who was involved in the incident leading up to the emergency use of a manual restraint; including the names of staff and persons receiving services who were involved;
  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 person who was manually restrained, leading up to, during, and following the manual restraint;

5. a description of the mental, physical, and emotional condition of the other persons involved leading up to, during, and following the manual restraint;
  6. whether there was any injury to the person 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 there was a debriefing with the staff and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident. 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 person's service recipient record. The record must be uniform and legible.
- D. Each single incident of emergency use of manual restraint must be reported separately. A single incident is when the following conditions have been met:
1. after implementing the manual restraint, staff attempt to release the person at the moment staff believe the person'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 person'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 5 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 of whether:
1. the person'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 persons, staff, or the services involved; and
  6. there is a need for corrective action by the program to protect the health and safety of persons.
- 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 internal review being completed.
- 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:

Quality Assurance Administrator

#### **X. Expanded Support Team Review of Emergency Use of Manual Restraint**

- A. Within 5 working days after the completion of the internal review, the program must consult with the expanded support team to:
  - 1. Discuss the incident to:
    - a. define the antecedent or event that gave rise to the behavior resulting in the manual restraint; and
    - b. identify the perceived function the behavior served.
  - 2. Determine whether the person's coordinated service and support plan addendum needs to be revised to:
    - a. positively and effectively help the person maintain stability; and
    - b. reduce or eliminate future occurrences of manual restraint.
- B. Robland HHC must maintain a written summary of the expanded support team's discussion and decisions in the person's service recipient record.
- C. Robland HHC has identified the following person or position responsible for conducting the expanded support team review and for ensuring that the person's coordinated service and support plan addendum is revised, when determined necessary.

Program Administrator

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

Within 5 working days after the completion of the expanded support team review, the program must submit the following to the Department of Human Services using the online behavior intervention reporting form which automatically routes the report to the Office of the Ombudsman for Mental Health and Developmental Disabilities:

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

#### **XIII Staff Training**

Before staff may implement manual restraints on an emergency basis the program must provide the training required in this section.

- A. Robland HHC must provide staff with orientation and annual training as required in Minnesota Statutes, section 245D.09.

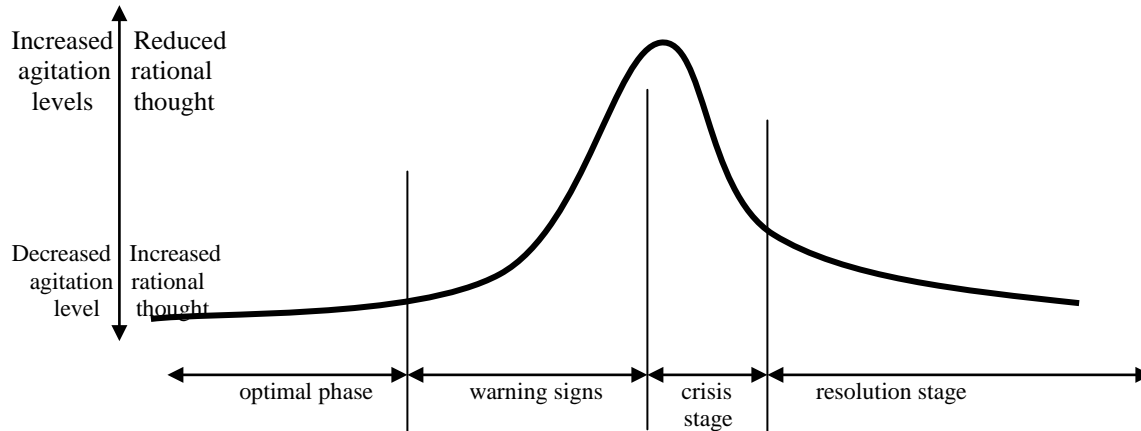
1. Before having unsupervised direct contact with persons served by the program, the program must provide instruction on prohibited procedures that address the following:
    - a. what constitutes the use of restraint, time out, seclusion, and chemical restraint;
    - b. staff responsibilities related 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 according to the requirements in Minnesota Statute, section 245D.061 and this policy.
  2. Within 60 days of hire the program must provide 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 how 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 person's physical signs of distress, including positional asphyxia;
    - f. the physiological and psychological impact on the person and the staff when restrictive procedures are used;
    - g. the communicative intent of behaviors; and
    - h. relationship building.
- B. Training on these topics received from other sources may count toward these requirements if received in the 12-month period before the staff person's date of hire or in the 12-month period before this program's 245D-HCBS license became effective on Jan. 1, 2014.
- C. Robland HHC must maintain documentation of the training received and of each staff



## Alternative Measures to Emergency Use of Manual Restraints

Some people may have difficulty dealing with anxiety and frustration due to their cognitive, communicative, and social abilities. Having a caregiver who can provide support to these individuals can be beneficial for all. Through a process of showing empathy, listening, and developing ideas, the caregiver can assist an agitated individual in even the most difficult situations.

People often go through a cycle of several stages when they exhibit undesirable behaviors. This is demonstrated in the diagram below. In this diagram of a typical behavior cycle, the person goes through four different stages. As he goes through each stage, his agitation levels and rational thought abilities go up and down. As the person's level of agitation rises, his/her ability to think clearly and rationally greatly decreases. Think of the last time that you dealt with a person who was frustrated and yelling. How clearly was that person thinking? How difficult was it to reason with that person?



### • ***Stage One: The optimal phase***

This stage is the most favorable stage for a person to be and a stage where things are doing well. The person feels good about himself and the people around him. In this stage, the person's agitation level is low. There is little anxiety or frustration. Because of the lack of these interferences, the person's ability to have rational, cohesive thoughts is high. This stage is optimal for teaching skills and reinforcing the desirable behaviors. Caregivers will want to work hard to keep the person on a positive momentum and optimal phase.

### • ***Stage Two: The warning signs***

In this stage, caregivers begin to notice a change in the person's behaviors, facial expressions, tone and volume of voice, and body language. These changes indicate that the person is becoming overly anxious or frustrated, and that more severe behaviors could be ahead. Typically, as the person progresses through this stage, the agitation level quickly begins to rise. As the agitation increases, the person's ability to think rationally decreases. For this reason, it is imperative that the staff react quickly to prevent the agitation level from rising. This is the stage where the caregiver should put forth the effort to help with problem solving. There is still potential for rational thought and decision making, which are needed to resolve the problem.

### • ***Stage Three: The crisis stage***

The third stage is often associated with large amounts of yelling, threatening, and aggressive or unsafe behavior. The person's agitation is extremely high, and the ability to think rationally is very low. Because of this, it is both ineffective and unsafe to do much of any interacting with the person. The emphasis in this stage should be on keeping everyone involved as safe as possible.

### • ***Stage Four: The resolution stage***

During this final stage, the episode begins to wind down. The person gradually becomes calmer, as evidenced by the subsiding of the aggressions, decrease in the volume and cadence of his/her voice, a slower heart rate, slower breathing, and relaxing of the muscles. As the person moves through this stage and back to optimal functioning, the agitation level decreases. This allows for the person to regain the ability to use rational and cohesive thought. In this stage, the caregiver should support the person in moving through this stage and back into stage one.

There should also be some caution used to assure that the person does not quickly move back into the second or third stage.

It is important that no behavior cycle will look the same. The intensity and the duration of each stage are different for each person and situation. For instance, in one episode, there could be very few warning signs and the person immediately jumps to the crisis stage; while during another episode, the warning signs stage is long and drawn out. One person could experience a crisis stage that lasts for nearly an hour, while another can be in the stage for only a few minutes. In one episode, a person could move smoothly from resolution stage and then into optimal functioning, while another could jump from the resolution stage back into a crisis situation. It is important to realize that staff can affect these stages through their actions

### **Hearing the call for help**

When people enter the warning sign stage, they often will not indicate they are in need of help with solving a problem. Thus, it becomes important for the caregivers to become skilled at reading the warning signs that indicate a need for help. It is often beneficial to make written lists of warning signs that the individual often exhibits when anxious or frustrated. This is a good way for caregivers to communicate with each other about what warning signs they are frequently seeing. Here are some examples of warning signs that may often be seen:

#### *• Warning Signs of Anxiety*

- Pacing
- Fidgeting
- Twitching
- No eye contact.
- Crying
- Inattention to tasks.
- Pressured speech
- Repeating questions
- Biting nails
- Picking skin or sores
- Covering face
- Yelling
- Increase in self-stimming behaviors.
- Increase in self-talk
- Facial expressions

#### *• Warning Signs of Frustration*

- Preceding event.
- Tense facial expressions
- Red face
- Mumbling
- Sounds of exasperation
- Talking louder
- Talking faster
- Change in the tone of voice
- Yelling
- Swearing
- Loss of eye contact
- Suddenly quiet
- Staring
- Threatening posture
- Irritability
- That "look"

### ***First Step: Stay Calm***

The first step caregivers should always do it to remain calm in the current situation. If the caregiver remains calm, you will be able to think clearly. Remember, the fact that people think less clearly and rationally when they are agitated also applies to the caregiver. If a caregiver is angry, emotional, and yelling at the consumer, it is likely that he/she will step up and match that level of intensity. On the other hand, if the caregiver is able to stay calm the consumer may match that emotion

### ***Second Step: Buying time***

Once the caregiver identifies warning signs and realizes the potential for escalated and out-of-control behaviors, he should focus on buying as much time in the low agitation/high rational thought level for as long as possible; This is where the problem solving can be done. Little can be done when the person has high agitation and low ability for rational thought. These are strategies that caregivers can use to keep the agitation down as long as possible:

### ***Repeating the request***

This is a technique that can be used to follow a person's request, especially when the answer is not an immediate "yes". The caregiver simply tells the individual what he just asked for. Ex: "You want pizza" or "You want to stay up later". This helps to buy time because the person is frequently expecting to hear "no". As soon as the "N.." comes out of the mouth, the situation quickly escalates. By repeating the request, the caregiver is essentially saying, "I'm not saying "no", let's talk it out." This may allow enough time for the agitation level to remain low enough to start a discussion.

### ***Giving the words***

It is common for people with developmental disabilities to exhibit undesirable behaviors because they are over-whelmed with frustration or anxiety and do not know how to express it. Asking a person to verbalize what is wrong may simply cause more agitation because it adds pressure. The caregiver should resist asking "What's wrong" or "What's your problem". Instead, the caregiver should start by giving the person very simple words to describe his feelings-- such as happy, sad, and frustrated. Here are some examples of good opening phrases:

- "You seem frustrated; I bet it is because you can't go to the movie now."
- "You seem frustrated; was it something that Kim said?"
- "I can tell you are angry; let's think about this calmly?"
- "I can tell you are angry, but I know we will get through this"
- "I think I upset you by what I said; let's talk about it"

Because communicating can be difficult work, the caregiver can give the person's brain a break by using this strategy. This can help to reduce agitation. When this is done consistently the person learns to identify specific words that are linked to how they are feeling. Eventually, they learn to use these words themselves. By giving the words, caregivers can also validate what the person is feeling. People often become frustrated and yell because they feel that they are not getting their point across or are not understood by other people. When they feel that they are validated, there is little need for such behaviors. The person is more likely to realize that the caregiver is going to work with him, not against him.

### ***Give the person your undivided attention***

This is not the time to multi-task. Caregivers should maintain eye contact with the consumer. Caregivers should go into an area where there will be few distractions, preferably where there are no other people who will try to interrupt or be distracted by television or the radio. It is also important there are no people, noises, or situations that will elevate the individual's agitation. Caregivers should use a room where both the caregiver and the individual can sit comfortably.

### ***Try to be non-judgmental***

Remember that the caregiver's goal is to listen. Caregivers should not correct the person or say contrary statements to what the individual is saying.

### ***Give feed-back***

Do not confuse this for giving advice. It is important for the caregiver to give feed-back that shows they are listening and they understand what the person is saying. Caregivers should give visual feedback by maintaining eye contact, nodding their head, and using affirming facial expressions that invite the person to keep talking. Employees should give verbal feedback by paraphrasing and restating what the person said. Employees can ask questions to clarify what the person is saying. Caregivers may also suggest words to describe how the person may be feeling and use few words to suggest they are listening and the person should keep talking such as, "Uh-huh", "okay", "sure", "I see", and "Go on".

### ***Allow silence for reflection***

Employees should pause and remaining silent, to show the person you are thinking about what he said. By using body language and facial expressions, employees will show the individual they are thinking about what was said. Pausing will also allow the person to take a breath, think about what he said and wants to say, and perhaps calm down.

### ***Write down the issues that the person is upset about***

This further reinforces the fact that the caregiver is listening to what is being said. The statements can also be used for future reference. The person may want to show this ideas or concerns to other people. If the individual continuing on with a rapid pace, the caregiver can repeat what he is saying as he is writing it down. He can gradually slow down the rate at which he repeats it, and the person may slow down so that he can keep up.

### ***Don't forget non-verbal communication.***

Caregivers should assure their body language, facial expressions, and tone of voice all convey the message they are there to help the person to get through the problem.

### ***Use Redirection***

Employees should refrain from using phrases such as, "No!", "Stop that!", "Knock it off!", "That's not nice", "That's inappropriate". This is not helpful for the individual as he probably knows the behavior is not appropriate, but he does not know a better way to handle the problem. Effective redirection involves shifting the persons focus from whatever it is that is making him upset or anxious to something that is more pleasant and calming. One way is to bring up another conversation. Bring up something totally different—something that he is going to be interested in talking about. Another great way to redirect is by initiating a new activity that the person will enjoy. "Let's go for a walk", "Let's bake some cookies", "Let's go watch a movie". With good redirection, do not have to point out what they are doing wrong, rather tell them what they should be doing instead.

### ***When the situation becomes a crisis....***

The caregivers focus is no longer on trying to calm the person down. The focus is now on keeping people safe—keeping the individual safe, keeping the other people in the area safe, and keeping yourself safe.

#### ***•Less is more***

Too often, caregivers try to talk too much to the person who is out of control. This often causes the behaviors to escalate even more. Remember, if the person is this far into the cycle, he is not being rational and will not listen to the caregiver.

*Give space.*

Caregivers should be at least an arm or leg length away. This is not only for their safety, it communicates respect and that they are not a threat to the person. Whenever possible, caregivers should watch the person from a distance, or even allow the person to be alone if it is safe to do so.

*Get other people out.*

Remove the audience that may be feeding into the behaviors. Get other people to a safe area. Remember to give them assurance and help keep them calm, or they may also begin to exhibit problem behaviors.

*Scan the room.*

- Look for things the person may use as a weapon. *Knives, bats, sticks, rocks, sharp objects, small objects that can be thrown, pictures, glasses, hard toys, and anything that can be swung.*
- Look for breakable items.
- Look for the exits. Caregivers should never let the person get between them and the exit.
- Look for furniture, barricades, and pillows that you can use to put between you and the person.
- Look for the phone.

**Call 911 if the situation escalated beyond staff control.**