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MEDICARE FRAUD WASTE & ABUSE

To complete the annual, federally mandated, Fraud, Waste, and Abuse Training and General Compliance Training you will need to access the reading material online**.** This training is mandatory for Robland employees.

If you do not have online access, the training material can be mailed, although its format is not ideal. Please attempt to gain access to the material online. If that is not possible, please contact our **245D Team** to request a copy be mailed to you.

Please follow the instructions below to access the training material on our website:

1) Visit www.Roblandhomehealth.com
2) Click on "***Required Trainings"*** on the top of the screen.
3) Select **"Annual Fraud, Waste, and Abuse Training"** and read through the entire material. *Please note that you do not need to take the tests included in the reading.*
4) When finished, select "**General Compliance Training"** and read through the entire material. *Please note that you do not need to take the tests included in the reading.*
5) When you have completed your review of *both* trainings please sign the appropriate signature page in your Basic Service Annual Training packet that was mailed to you.

DATA PRIVACY REQUIREMENTS (HIPAA)

POLICY:

Robland Home Health recognizes the right of each person receiving services in this program to confidentiality and data privacy. This policy provides general guidelines and principles for safeguarding service recipient rights to data privacy under section 245D.04, subdivision 3(a) and access to their records under section 245D.095, subdivision 4, of the 245D Home and Community-based Services Standards.

PROCEDURE:

A. Private Data

1. Private data includes all information on persons that has been gathered by Robland or from other sources for program purposes as contained in an individual data file, including their presence and status in this program.
2. Data is private if it is about individuals and is classified as private by state or federal law. Only the following persons are permitted access to private data:
   a. The individual who is the subject of the data or a legal representative.
   b. Anyone to whom the individual gives signed consent to view the data.
   c. Employees of the welfare system whose work assignments reasonably require access to the data. This includes staff persons in this program.
   d. Anyone the law says can view the data.
   e. Data collected within the welfare system about individuals are considered welfare data. Welfare data is private data on individuals; including medical and/or health data. Agencies in the welfare system include, but are not limited to: Department of Human Services; local social services agencies, including a person's case manager; county welfare agencies; human services boards; the Office of Ombudsman for Mental Health and Developmental Disabilities; and persons and entities under contract with any of the above agencies; this includes this program and other licensed caregivers jointly providing services to the same person.
   f. Once informed consent has been obtained from the person or the legal representative there is no prohibition against sharing welfare data with other persons or entities within the welfare system for the purposes of planning, developing, coordinating and implementing needed services
   g. Data created prior to the death of a person retains the same legal classification (public, private, confidential) after the person's death that it had before the death.

B. Providing Notice

At the time of service initiation, the person and his/her legal representative, if any, will be notified of Robland's data privacy policy. Staff will document that this information was provided to the individual and/or their legal representative in the individual record.

C. Obtaining Informed Consent or Authorization for Release of Information

1. At the time informed consent is being obtained staff must tell the person or the legal representative individual the following:
   a. why the data is being collected;
   b. how the agency intends to use the information;
   c. whether the individual may refuse or is legally required to furnish the information;
   d. what known consequences may result from either providing or refusing to disclose the information; and with whom the collecting agency is authorized by law to share the data. What the individual can do if they believe the information is incorrect or incomplete;
   e. how the individual can see and get copies of the data collected about them; and any other rights that the individual may have regarding the specific type of information collected.
2. A proper informed consent or authorization for release of information form must include these factors (unless otherwise prescribed by the HIPAA Standards of Privacy of Individually Identifiable Health Information 45 C.F.R. section 164):
   a. be written in plain language;
   b. be dated;
   c. designate the particular agencies or person(s) who will get the information;
   d. specify the information which will be released;
   e. indicate the specific agencies or person who will release the information;
   f. specify the purposes for which the information will be used immediately and in the future;
   g. contain a reasonable expiration date of no more than one year; and
   h. specify the consequences for the person by signing the consent form, including: "Consequences: I know that state and federal privacy laws protect my records. I know:
      - Why I am being asked to release this information.
      - I do not have to consent to the release of this information. But not doing so may affect this program's ability to provide needed services to me.
      - If I do not consent, the information will not be released unless the law otherwise allows it.
      - I may stop this consent with a written notice at any time, but this written notice will not affect information this program has already released.
      - The person(s) or agency(s) who get my information may be able to pass it on to others.
      - If my information is passed on to others by this program, it may no longer be protected by this authorization.
      - This consent will end one year from the date I sign it, unless the law allows for a longer period."
   i. Maintain all informed consent documents in the consumer's individual record.

D. Staff Access to Private Data

1. This policy applies to all program staff, volunteers, and persons or agencies under contract with Robland (paid or unpaid).
2. Staff persons do not automatically have access to private data about the persons served by Robland or about other staff or agency personnel. Staff persons must have a specific work function need for the information. Private data about persons are available only to Robland employees whose work assignments reasonably require access to the data; or who are authorized by law to have access to the data.
3. Any written or verbal exchanges about a person's private information by staff with other staff or any other persons will be done in such a way as to preserve confidentiality, protect data privacy, and respect the dignity of the person whose private data is being shared.
4. As a general rule, doubts about the correctness of sharing information should be referred to the supervisor.

E. Individual access to private data.

Individuals or their legal representatives have a right to access and review the individual record.

1. A staff person will be present during the review and will make an entry in the person's progress notes as to the person who accessed the record, date and time of review, and list any copies made from the record.
2. An individual may challenge the accuracy or completeness of information contained in the record. Staff will refer the individual to the grievance policy for lodging a complaint.
3. Individuals may request copies of pages in their record.
4. No individual, legal representative, staff person, or anyone else may permanently remove or destroy any portion of the person's record.

F. Case manager access to private data.

A person's case manager and the foster care licensor have access to the records of persons served by Robland under section 245D.095, subd. 4.

G. Requesting Information from Other Licensed Caregivers or Primary Health Care Providers.

5. Complete the attached release of information authorization form. Carefully list all the consults, reports or assessments needed, giving specific dates whenever possible. Also, identify the purpose for the request.
6. Clearly identify the recipient of information. If information is to be sent to the program's health care consultant or other staff at the program, include Attention: (name of person to receive the information), and the name and address of the program.
7. Assure informed consent to share the requested private data with the person or entity has been obtained from the person or the legal representative.
8. Keep the document in the person's record.

Date of last policy review: 01/01/2024 Date of last policy revision: 01/01/2024 Legal Authority: MS § 245D.11, subd. 3

SERVICE RECIPIENT RIGHTS REQUIREMENTS

Each individual receives a copy of their rights at the time of intake and annually thereafter. Should rights ever change, a new copy of the rights will be given to the participants and staff immediately upon the change as well. This packet contains information regarding their rights while receiving services and supports from this program, information on restriction of their rights, and information of where they can go if they have questions or need additional information related to their rights. A copy of the packet is below.

We explain to our service recipients to be sure that they understand that they may contact the agencies below if they need help to exercise or protect their rights:

Office of the Ombudsman for Mental Health Center and Developmental Disabilities
121 7th Place E, Suite 420
Metro Square Building
mndlc@mylegalaid.org St. Paul, MN 55101
Phone: (651) 7567-1800 or 1(800) 657-3506
Fax: (651) 797-1950 Website: www.ombudmhdd.state.mn.us

Minnesota Disability Law
430 1st Ave N, Suite 300
Minneapolis, MN 55401
Email:
Website: http://www.mndlc.org/

We then let all service recipients know that this program is licensed under Minnesota Statutes, Chapter 245D. Under this statute, Robland employees must help clients exercise and protect their rights as identified in Minnesota Statutes, section 245D.04.

When receiving services and supports from this program name, participants have the right to:

1. Take part in planning and evaluating the services that will be provided to me.
2. Have services and supports provided to me in way that respects me and considers my preferences, (including personal items in my bedroom).
3. Refuse or stop services and be informed about what will happen if I refuse or stop services.
4. Know, before I start to receive services from this program, if the program has the skills and ability to meet my need for services and supports.
5. Know the conditions and terms governing the provision of services, including the program's admission criteria and policies and procedures related to temporary service suspension and service termination.
6. Have the program help coordinate my care if I transfer to another provider to ensure continuity of care.
7. Know what services this program provides and how much they cost, regardless of who will be paying for the services, and to be notified if those charges changes.
8. Know, before I start to receive services, if the cost of my care will be paid for by insurance, government funding, or other sources, and be told of any charges I may have to pay.
9. To have staff that is trained and qualified to meet my needs and support.

10. Have my personal, financial, service, health, and medical information kept private and be notified if these records have been shared.
11. Have access to my records and recorded information that the program has about me as allowed by state and federal law, regulation, or rule.
12. Be free from abuse, neglect or financial exploitation by the program or its staff.
13. Be free from staff trying to control my behavior by physically holding me or using a restraint to keep me from moving, giving me medication I don't want to take or that isn't prescribed for me, or putting me in time out, seclusion, restrictive intervention; except if and when manual restraint is needed in an emergency to protect me or others from physical harm.
14. Receive services in a clean and safe location.
15. Be treated with courtesy and respect, have access to and respectful treatment of my personal possessions at any time, including financial resources.
16. Be allowed to reasonably follow my cultural and ethnic practices and religion.
17. Be free from prejudice and harassment regarding my race, gender, age, disability, spirituality, and sexual orientation.
18. Be told about and to use the program's grievance policy and procedures, including knowing how to contact persons responsible for helping me to get my problems with the program fixed and how to file a social services appeal under the law.
19. Know the names, addresses and phone numbers of people who can help me, including the ombudsman, and to be given information about how to file a complaint with these offices.
20. Exercise my rights on my own or have a family member or another person help me exercise my rights, without retaliation from the program.
21. Give or not give written informed consent to take part in any research or experimental treatment.
22. Choose my own friends and spend time with them.
23. Have personal privacy, including the right to use a lock on my bedroom door.
24. Take part in activities that I choose.

RESIDENTIAL SERVICES AND SUPPORTS (meaning out-of-home crisis respite, supported living services, foster care services in a foster care home or a community residential setting) MUST INCLUDE THESE ADDITIONAL RIGHTS: ***(These are not included for ILS/IHFS/PSR)***

1. Have free, daily, private access to and use of a telephone for local calls, and long-distance calls made collect or paid for by me.
2. Receive and send mail and emails and not have them opened by anyone else unless I ask.
3. Use of and have free access to common areas (this includes access to food at any time) and the freedom to come and go at will.
4. Choose who visits, when they visit and to have visits in private (including bedroom) with my spouse, family, legal counsel, religious guide, or others allowed in Minnesota Human Services Rights Act, Minnesota Statutes, section 363A.09.
5. Have access to three nutritious meals, nutritious snacks between meals each day, and access to food and water at any time.

6. Choose how to furnish and decorate my bedroom or living unit.
7. A home that is clean, safe, and meets the requirements of a dwelling unit as defined in state fire code.

CAN ANY RIGHTS BE RESTRICTED?
Restriction of an individual's rights is allowed only if determined necessary to ensure their health, safety, and well-being. Any restriction of a person's rights must be documented in their coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the individual and provide them support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner.

WHAT IS THE PROGRAM REQUIRED TO DO IF ANY RIGHTS WILL BE RESTRICTED?
Before this program may restrict a participant's rights in way this program must document the following information:

1. The justification (meaning the reason) for the restriction based on an assessment of what makes that specific individual vulnerable to harm or maltreatment if they were allowed to exercise the right without a restriction;
2. The objective measures set as conditions for ending the restriction (meaning the program must clearly identify when everyone will know the restriction is no longer needed and it has to end);
3. A schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager (meaning that at least every six months, more often if they want, the program must review with the individual and their authorized representative or legal representative and case manager, why the restriction is still needed and how the restriction should change to allow the person as much freedom as possible to exercise the right being restricted); and
4. Signed and dated approval for the restriction from the client or their legal representative, if any.

CAN THE PROGRAM RESTRICT ALL OF THE RIGHTS?
The program cannot restrict any right they chose. The only rights the program may restrict, after documenting the need, include:

1. The right to associate with other persons of a client's choice;
2. The right to have personal privacy; and
3. The right to engage in activities that the client chooses.

Additional rights for persons living in community residential settings ***(not for ILS/IFHS/PSR clients)***:

4. The right to have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

5. The right to receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication; and
6. The right to have use of and free access to common areas in the residence; and
7. The right to privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom.

WHAT IF A PARTICIPANT DOESN'T GIVE THEIR APPROVAL?
A restriction of an individual's rights may be implemented only after they or their guardian have given approval.

WHAT IF THEY WANT TO END THEIR APPROVAL?
A participant may withdraw their approval of the restriction of their right(s) at any time. If they do withdraw their approval, the right must be immediately and fully restored.

MALTREATMENT REPORTING (VULNERABLE ADULTS & MALTREAMENT OF MINORS)

VULNERABLE ADULTS

INTRODUCTION

In our community, there are adults experiencing maltreatment who need our help. Examples of maltreatment include abuse, neglect and financial exploitation. To help them find safety and security, the community needs to know about these problems and what to do about it.

This training is designed to help you learn more about the maltreatment of vulnerable adults and what you can do to help. If you are a mandated reporter, it will help you learn more about your duty to report suspected maltreatment. If you are a relative, friend, neighbor, or other interested person, this training will help you understand the adult protection system and assist you in finding protective services for someone in need.

Anyone of us may need protective services at some point in life. As you help your vulnerable clients, relatives, friends and neighbors, remember that you are strengthening a system that you too may need. If you have any questions after reading this training, you can get more information from your local county human service agency. Ask for the social worker who is familiar with adult protection services.

DEFINITIONS

Who is a vulnerable adult?

A "vulnerable adult' is any person, 18 years of age or older, who is a resident or patient of a facility such as a hospital, group home, nursing home, day service facility, day activity center, adult foster care home, or a person who receives services during the day from an agency that is licensed/certified by the Minnesota Department of Human Services or the Minnesota Department of Health such as a home care agency or a personal care services.

A vulnerable adult also includes a person who, regardless of where they live or what type of services they receive, possess a physical or mental infirmity or other physical, mental, or emotional dysfunction that impairs the individual's ability to provide adequately for their own care without assistance **AND** because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect themselves from maltreatment.

Conservatorship

Conservatorship is when a legal proceeding in which one person is appointed to act as a substitute decision-maker for another person. Conservatorship does not presume that the incapacitated person is incompetent in all areas of his/her life. It can be tailor-made to meet the needs of the individual. Additionally, persons under conservatorships can be voluntary or involuntary and can be of the person and/or estate.

Guardianship
Guardianship is when legal proceeding in which a person is appointed to act as a substitute decision-maker for another person. This is the most restrictive option. A person under guardianship loses **all** rights. The guardian becomes responsible for all aspects of the incapacitated person's life.

REPORTING
Who is required to report adult maltreatment?
"Mandated Reporters" include professionals or professional delegates while engaged in "the care of vulnerable adults." Some of the professions identified as mandated reporters include: law enforcement, education and most health-care related professionals including nursing home administration, nursing, medicine, social work and psychology. A mandated reporter who has reason to believe a vulnerable adult is being or has been maltreated, or has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately (within 24 hours) report.

ANY employee or volunteer of a public or private facility or agency caring for vulnerable adults, including employees not generally involved with patient care (maintenance and food services staff, etc.) must comply with this law.

ANY person concerned about the well-being of a vulnerable adult may report known or suspected maltreatment.

Where do I report maltreatment?
Any incident of known or suspected maltreatment should be reported to MAARC (Minnesota Adult Abuse Reporting Line). MAARC is reachable 24/7/365 at 1(844) 880-1574, or online at: https://tnt09.agileapps.dhs.state.mn.us/networking/sites/880862836/MAARC.
Nothing in the law prevents a reporter from also reporting to a law enforcement agency.
A mandated reporter may meet the reporting requirements by reporting to an internal reporting system; then the facility remains responsible for complying with immediate reporting requirements. A facility may not prohibit a mandated reporter from reporting externally and is prohibited from retaliating against a mandated reporter who reports in good faith.

How do I report suspected maltreatment and is my report confidential?
Mandated reporters must make oral reports to MAARC or through their internal reporting system. To the extent possible, all reporters should be prepared to identify the vulnerable adult and the caregiver; the nature and extent of the suspected maltreatment; and any evidence of previous maltreatment; the time, date and location of the incident; and other information regarding the situation.
Written reports are no longer required, nor are they a substitute for a call to MAARC. The identity of the reporter may not be released unless the reporter has given consent or by a court order.

Are there any exemptions from the reporting requirements?
Federal law specifically prohibits release of patient-identifying information without patient consent in

certain federal-funded programs such as chemical dependency programs.

- Resident to resident physical or verbal abuse, of self-abusive behavior not causing serious harm-based on contingencies of the situation and the severity of the circumstances.
- Accidents: sudden, unforeseen and unexpected event which is not likely to occur, event which could not have been prevented by exercise of due care, when facility is compliant with relevant rules and laws
- Individual's single mistake: when providing therapeutic conduct, no injury or harm which reasonably requires care of physician or mental health professional, if reported internally and documented for outside review

What is the penalty for failing to report suspected maltreatment?

If you are mandated by law to report suspected maltreatment and negligently or intentionally fail to report, you can be held liable for any damages or harm caused by your failure to report the maltreatment. There are also criminal charges for failure to report.

Are there protections for reporting maltreatment?

- Immunity from civil or criminal liabilities for good faith reports
- Identity of reporter is not released without consent of the reporter or by a court order
- There are penalties for retaliation against reporter
- There is civil protection for good faith investigation activities

What happens when a report is filed?

If MAARC determines maltreatment to a vulnerable adult has occurred, the report will be referred to either the county where the abuse occurred, the Minnesota Department of Health or the Minnesota Department of Human Services. Law enforcement may also be contacted if there is reason to believe criminal activity has taken place.

What are the penalties for adult maltreatment?

- Lose the right to work in a facility or agency
- Lose professional license
- Be subject to criminal penalties

What are some of the protective services available to vulnerable adults?

- A restraining order
- A court order for removal of the perpetrator from the residence of the vulnerable adult
- The appointment of a guardian or conservator by a court
- The replacement of a guardian or conservator suspected of maltreatment
- A referral to the prosecuting attorney for possible criminal prosecution of the perpetrator

Adult Protection Workers cannot solve every problem. Even vulnerable adults have the right to make decision, possibly bad ones. Adult protection works may follow an individual case for months before they are able to establish a pattern and intervene in the person's best interests.

MALTREATMENT OF MINORS ACT

Overview of the Maltreatment of Minors Act
The Minnesota Maltreatment of Minors Act establishes a system for reporting possible child abuse and neglect to government agencies that provide protective services for the child or conduct criminal investigations. The act also governs agency responses to reports and access to information generated under the act. Some of the system's features are determined by requirements in federal law that the state must satisfy in order to qualify for federal child abuse prevention and treatment grants. This information brief provides an overview of the Maltreatment of Minors Act, Minnesota Statutes, section 626.556 and related law and rules.

THE REPORTER
Who is permitted to report child abuse or neglect?
Anyone who knows, or has reason to believe, or suspects that a child is being, or has been, neglected or abused.

Who is required to report child abuse or neglect?
An individual who knows or has reason to believe a child is being neglected or abused, and who is:

(1) A member of the clergy who receives the information while engaged in ministerial duties, excluding information exempt under the confessional privilege; or
(2) A professional or the professional's delegate who is engaged in
    - The healing arts
    - Social services, including employee assistance counseling and guardian ad litem services
    - Hospital administration
    - Psychological or psychiatric treatment
    - Child care
    - Education
    - Law enforcement

A parent, guardian, or caretaker who knows or reasonably should know a child's health is in serious danger must report neglect. These individuals are subject to criminal penalties for failing to report if the child suffers substantial or great bodily harm or dies for lack of medical care. The criminal law that permits reliance on spiritual means or prayer for health care does not eliminate this reporting duty.

What are an employer's obligations to an employee who reports neglect or abuse?
The employer may not retaliate against an employee who is required to report and does so in good faith.

What is the penalty for failing to make a required report?
It is a misdemeanor exclusively prosecuted by the county attorney rather than the city attorney who usually prosecutes misdemeanors.

What are the consequences of making a false report?
An individual who makes a false report in good faith is immune from civil or criminal liability. An individual who knowingly makes a false report is liable in a civil suit for actual and punitive damages, costs, & attorney fees.

REPORTABLE ABUSE & NEGLECT
Whose abuse or neglect is reportable under the act?
Persons Responsible for the Child's Care:

- Parent/Guardian
- Teacher
- School Administrator
- School Employees or Agents
- Daycare Provider
- Paid or Unpaid Babysitter
- Counselor / Coach
- Other lawful custodian with care responsibilities

What is "abuse" under the act?
Physical Abuse – physical abuse or threatened physical abuse occurring within the preceding three years, including:

- Physical injury, mental injury, or threatened injury inflicted other than by accident
- Physical or mental injury not reasonably explained by the child's history of injuries
- Aversive or deprivation procedures (e.g., electric shock) not authorized by Department of Human Services rules
- Regulated interventions (e.g., time out) not authorized by Department of Children, Families and Learning Rules

Excluded from this definition is reasonable and moderate discipline by a parent or guardian or use of reasonable force by a teacher, principal, or school employee.

Sexual Abuse – sexual abuse or threatened sexual abuse occurring within the preceding three years, including:

- Criminal sexual conduct
- Soliciting a child to practice prostitution
- Receiving profit derived from prostitution by a child
- Hiring or agreeing to hire a child as a prostitute
- Using a minor in a sexual performance or pornographic work

What is "neglect" under the act?
Within the preceding three years:

- Failure to supply necessary food, clothing, shelter, or medical care
- Failure to protect a child from serious danger to physical or mental health when reasonably able to do so
- Failure to provide necessary supervision or appropriate child care
- Chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the child's care that adversely affects the child's basic needs and safety
- Emotional harm demonstrated by a substantial and observable effect on the child
- Withholding medically indicated treatment from a disabled infant with a life-threatening condition
- Prenatal exposure to specified controlled substances
- Failure to ensure that a child is educated in accordance with state law

What else must be reported under the act?
A mandated reporter must report to law enforcement kidnapping or actions that deprive a parent of custodial or parenting time rights. This report does not trigger a local social services agency assessment.

Person in a Position of Authority: A parent or someone acting in a parent's place who has responsibility for the health, welfare, or supervision of a child for any period of time, however brief.

Person with a Significant Relationship to the Child: A person who has a significant relationship to the child because of being a relative or stepparent, or because of intermittently residing in the child's home.

CREATION OF REPORTS
Where can a child abuse report be made?
In most cases a person may report to either the police or county sheriff or the local social services agency.

Exceptions:

- If a person required to report believes a child died because of neglect or abuse, the report must be made to the medical examiner or coroner
- If abuse or neglect occurs in a licensed facility (day care, foster care, etc.) a person required to report must report to the agency that licenses the facility
- If abuse or neglect occurs in a school, a board or licensing entity must provide information about the circumstances of the alleged maltreatment to the Department of Children, Families and Learning

How is a report made?
The initial report may be oral. If the reporter is an individual required to report under the act, an oral report must be followed by a written report within 72 hours, exclusive of weekends or holidays.

What must be included in the report?
- The child's identity
- The person believed responsible for the abuse or neglect, if known
- The nature and extent of abuse or neglect
- The reporter's name and address

INVESTIGATION OR ASSESSMENTS OF REPORTS
How are reports of abuse or neglect in the home handled?
The local social services agency will conduct an assessment and determine (1) whether there was maltreatment, and (2) whether protective services are needed. If an incident results in the death of a child, the local social services agency may rely on the law enforcement investigation to determine whether there was maltreatment.

A determination that protective services are needed should result when a child protection worker concludes that (1) there is significant risk of maltreatment, and (2) persons responsible for the child's care are not likely to protect the child from maltreatment. When necessary, the agency may remove the child from the home. In cases alleging criminal sexual abuse, physical abuse, or criminal child neglect or endangerment, the local social services agency and local law enforcement must coordinate efforts to avoid duplicate fact-finding and multiple interviews. The social service or law enforcement agency may interview the alleged victim and other children (1) without parental consent, and (2) outside the parent or alleged offender's presence.

What are the requirements for assessments and investigations?
The act provides various protocols. It lists several relevant kinds of information the local social services agency or agency responsible for assessing or investigating the report should collect, and authorizes the agency to collect additional information.

The agency is required to interview the alleged perpetrator and victim. Audio recordings of interviews are to be made whenever possible, except that in sexual abuse cases videotaping is required. The act authorizes the agency to make an early determination of no maltreatment and close the case if there is no basis for further information. Determinations whether there is maltreatment and whether protective services are needed must be based on a preponderance of the evidence.

A person conducting an assessment should not have:
- A financial interest in a child abuse or neglect treatment provider, or
- A personal or family relationship with anyone under investigation

If an independent assessor isn't available, the services of someone who doesn't satisfy these requirements may be used.

Is there an appeal process?

- **YES:** A person acting on the child's behalf or the individual/facility determined to have maltreated the child may ask for reconsideration. However, all requests must be submitted in writing 15 days after receipt of final determination.
- If denied or not acted on in the 15 days, may make a request to Department of Human Services. The department then holds a hearing in order to reach a decision within 90 days. But either party can make an extension to have the hearing postponed.
- For facility maltreatment of a child, a person on their behalf may request that the review panel investigate the agency's maltreatment determination. The panel is the commissioners of health, human services, children, families, and the ombudsman for crime victims as well as mental health/retardation, or their designees.
- 30 days of the review, the panel must notify the agency and person of whether: (A) the panel agrees with the determination, or (B) must reconsider. If (B) the agency must report back to the panel with its reconsidered determination within 30 days. If the agency changes its determination or review, they must notify parties who got notice of the original determination.

What is the potential legal liability of those involved in child abuse cases?

If action is taken in good faith, there is immunity from civil or criminal liability for:

- A voluntary or mandated reporter
- Anyone who participates in a case assessment
- A school or licensed facility and its employees when permitting interviews and helping with an assessment or investigation
- A person performing duties under the act or the supervisor of such person

What are county alternative response programs?

Counties may establish programs that use alternative responses, instead of traditional investigative responses, to child maltreatment reports. A family's participation in an alternative response program is voluntary. The programs may include alternative approaches to assessing and providing appropriate services to a family following a child maltreatment report. Counties that use an alternative response program are still required to notify law enforcement of child maltreatment reports. A county may not use an alternative response program for reports involving maltreatment in licensed facilities, unlicensed personal care settings, or schools, or reports involving substantial child endangerment.

What do Vulnerable Adults and Maltreatment of Minors have in common?

Both are susceptible to abuse in many different ways: Here is a list of types of abuses that both sets of individuals have in common.

1. **Neglect**
    - Failure or omission by caregiver to provide for basic needs such as: food, health care, clothing, shelter and supervision
    - Neglect may be committed by: caregiver or self
    - It is not neglect for an authorized person to make decision in good faith to give or withhold health care, feeding or spiritual means of healing
    - It is not neglect for a vulnerable adult to make decision on their own behalf which place them at risk when they understand the consequences of the decision
    - Criminal penalties are in effect for some kinds of neglect
2. **Abuse**
    - Assault in the first through fifth degrees
    - Criminal sexual conduct in the first through fifth degrees
    - Conduct producing pain or injury: verbal abuse, hitting, slapping, kicking, corporal punishment, etc., Rule 40 violations (unauthorized use of aversive or deprivation procedures for persons with mental retardation or developmental disabilities), involuntary confinement, deprivation
    - Use of drugs to injure or facilitate a crime
    - Promotion of prostitution
    - Staff/facility sexual contact: unless pre-existing consensual sexual relationship, unless consensual sexual relationship with a Personal Care Attendant (PCA)
    - Criminal penalties now are in effect for some kinds of abuse
3. **Financial Exploitation**
    - When there is a legal financial relationship (such as Guardians, Power of Attorney, Conservators): unauthorized use of a vulnerable adult's money or assets, failure to use a vulnerable adult's money and assets resulting in harm to the vulnerable adult
    - In absence of legal authority: willful use, withholding or disposal of a vulnerable adult's money and assets, obtaining control of a vulnerable adult's money and assets by fraud, coercion or harassment
    - There are criminal penalties for financial exploitation
4. **Serious Maltreatment**
    - Amended to include neglect when it results in criminal sexual conduct against a child or vulnerable adult

What are the differences between the two?

- Who to report to and Maltreatment of Minors Act does not include financial exploitation, but that does not mean that it cannot happen in certain circumstances.

245D HOME AND COMMUNITY-BASED SERVICES INCIDENT RESPONSE, REPORTING & REVIEW

POLICY:
It is the policy of Robland Home Health to respond to, report, and review all incidents that occur while providing services in a timely and effective manner in order to protect the health and safety of and minimize risk of harm to persons receiving services.

"Incident" means an occurrence which involves a person and requires Robland to make a response that is not part of the program's ordinary provision of services to that person, and includes:

A. Serious injury of a person;
   1. Fractures;
   2. Dislocations;
   3. Evidence of internal injuries;
   4. Head injuries with loss of consciousness;
   5. Lacerations involving injuries to tendons or organs and those for which complications are present;
   6. Extensive second degree or third-degree burns and other burns for which complications are present;
   7. Extensive second degree or third-degree frostbite, and other frostbite for which complications are present;
   8. Irreversible mobility or avulsion of teeth;
   9. Injuries to the eyeball;
   10. Ingestion of foreign substances and objects that are harmful;
   11. Near drowning;
   12. Heat exhaustion or sunstroke; and
   13. All other injuries considered serious by a physician.

B. A person's death.

C. Any medical emergencies, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911, physician treatment, or hospitalization.

D. Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team.

E. An act or situation involving a person that requires to program to call 911, law enforcement, or the fire department.

F. A person's unauthorized or unexplained absence from a program.

G. Conduct by a person receiving services against another person receiving services that:
   1. Is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;
   2. Places the person in actual and reasonable fear of harm;
   3. Places the person in actual and reasonable fear of damage to property of the person; or
   4. Substantially disrupts the orderly operation of the program.

H. Any sexual activity between persons receiving services involving force or coercion.
   - "Force" means the infliction, attempted infliction, or threatened infliction by the actor of bodily or commission or threat of any other crime by the actor against the complainant or another, harm which (a) causes the complainant to reasonably believe that the actor has the present ability to execute the threat and (b) if the actor does not have a significant relationship to the complainant, also causes the complainant to submit.
   - "Coercion" means words or circumstances that cause the complainant reasonably to fear that the actor will inflict bodily harm upon, or hold in confinement, the complainant or another, or force the complainant to submit to sexual penetration or contact (but proof of coercion does not require proof of a specific act or threat).

H. Any emergency use of manual restraint.

I. A report of alleged or suspected child or vulnerable adult maltreatment.

RESPONSE PROCEDURE:

A. Serious injury
   1. In the event of a serious injury, staff will provide emergency first aid following instructions received during training.
   2. Summon additional staff, if they are immediately available, to assist in providing emergency first aid or seeking emergency medical care.
   3. Seek medical attention, including calling 911 for emergency medical care, as soon as possible.

B. Death
   1. If staff is alone, immediately call 911 and follow directives given to you by the emergency responder.
   2. If there is another person(s) with you, ask them to call 911, and follow directives given to you by the emergency responder.

C. Medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition
   1. Assess if the person requires the program to call 911, seek physician treatment, or hospitalization.
   2. When staff believes that a person is experiencing a life-threatening medical emergency, they must immediately call 911.
   3. Staff will provide emergency first aid as trained or directed until further emergency medical care arrives at the program or the person is taken to a physician or hospital for treatment.

D. Mental health crisis
   When staff believes that a person is experiencing a mental health crisis, they must call 911 or the county's mental health crisis intervention team.

E. Requiring 911, law enforcement, or fire department
   1. For incidents requiring law enforcement or the fire department, staff will call 911.
   2. For non-emergency incidents requiring law enforcement, staff will call 911 and state "this is not a life-threatening emergency".
   3. For non-emergency incidents requiring the fire department, staff will call 911 and state "this is not a life-threatening emergency".
   4. Staff will explain to the need for assistance to the emergency personnel.
   5. Staff will answer all questions asked and follow instructions given by the emergency personnel responding to the call.

F. Unauthorized or unexplained absence. When a person is determined to be missing or has an unauthorized or unexplained absence, staff will take the following steps:
   1. If the person has a specific plan outlined in his/her Coordinated Services and Support Plan Addendum to address strategies in the event of unauthorized or unexplained absences that procedure should be implemented immediately, unless special circumstances warrant otherwise.
   2. An immediate and thorough search of the immediate area that the person was last seen will be completed by available staff. When two staff persons are available, the immediate area and surrounding neighborhood will be searched by one staff person. The second staff person will remain at the program location. Other persons receiving services will not be left unsupervised to conduct the search.
   3. If after no more than 15 minutes, the search of the facility and neighborhood is unsuccessful, staff will contact law enforcement authorities.
   4. After contacting law enforcement, staff will notify their Emergency On-Call who will determine if additional staff is needed to assist in the search.
   5. When the person is found staff will return the person to the service site, or make necessary arrangements for the person to be returned to the service site.

G. Conduct of the person
When a person is exhibiting conduct against another person receiving services that is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support; places the person in actual and reasonable fear of harm; places the person in actual and reasonable fear of damage to property of the person; or substantially disrupts the orderly operation of the program, staff will take the following steps:

1. Summon additional staff, if available. If injury to a person has occurred or there is eminent possibility of injury to a person, implement approved therapeutic intervention procedures following the policy on emergency use of manual restraints (see EUMR Policy).
2. As applicable, implement the Coordinated Service and Support Plan Addendum for the person.
3. After the situation is brought under control, question the person(s) as to any injuries and visually observe their condition for any signs of injury. If injuries are noted, provide necessary treatment and contact medical personnel if indicated.

H. Sexual activity involving force or coercion
If a person is involved in sexual activity with another person receiving services and that sexual activity involves force or coercion, staff will take the following steps:

1. Instruct the person in a calm, matter-of-fact, and non-judgmental manner to discontinue the activity. Do not react emotionally to the person's interaction. Verbally direct each person to separate area.
2. If the person does not respond to a verbal redirection, intervene to protect the person from force or coercion, following the EUMR Policy as needed.
3. Summon additional staff if necessary and feasible.
4. If the persons are unclothed, provide them with appropriate clothing. Do not have them redress in the clothing that they were wearing.
5. Do not allow them to bathe or shower until law enforcement has responded and cleared this action.
6. Contact law enforcement as soon as possible and follow all instructions.
7. lf the person(s) expresses physical discomfort and/or emotional distress, or for other reasons you feel it necessary, contact medical personnel as soon as possible. Follow all directions provided by medical personnel.

I. Emergency use of manual restraint
(EUMR) Follow the EUMR Policy.

J. Maltreatment
Follow the Maltreatment of Minors or Vulnerable Adult Reporting Policy.

REPORTING PROCEDURE:

A. Completing a report
   1. Incident reports will be completed as soon possible after the occurrence, but no later than 24 hours after the incident occurred or Robland became aware of the occurrence. The written report will include:
      a. The name of the person or persons involved in the incident;
      b. The date, time, and location of the incident;
      c. A description of the incident;
      d. A description of the response to the incident and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;
      e. The name of the staff person or persons who responded to the incident; and
      f. The results of the review of the incident (see section IV).
   2. When the incident involves more than one person, Robland will not disclose personally identifiable information about any other person when making the report to the legal representative or designated emergency contact and case manager, unless this program has consent of the person. The written report will not contain the name or initials of the other person(s) involved in the incident.

B. Reporting incidents to team members
   1. All incidents must be reported to the person's legal representative or designated emergency contact and case manager:
      a. within 24 hours of the incident occurring while services were provided;
      b. within 24 hours of discovery or receipt of information that an incident occurred; or
      c. as otherwise directed in a person's coordinated service and support plan or coordinated service and support plan addendum.
   2. Robland will not report an incident when it has a reason to know that the incident has already been reported.
   4. Any emergency use of manual restraint of a person must be verbally reported to the person's legal representative or designated emergency contact and case manager within 24 hours of the occurrence. The written report must be completed according to the requirements in Robland's emergency use of manual restraints policy.

C. Additional reporting requirements for deaths and serious injuries
   1. A report of the death or serious injury of a person must be reported to both the Department of Human Services Licensing Division and the Office of Ombudsman for Mental Health and Developmental Disabilities.
   2. The report must be made within 24 hours of the death or serious injury occurring while services were provided or within 24 hours of receipt of information that the death or serious injury occurred.
   3. Robland will not report a death or serious injury when it has a reason to know that the death or serious injury has already been reported to the required agencies.

D. Additional reporting requirements for maltreatment
   1. When reporting maltreatment, Robland must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment.
   2. The report to the case manager must disclose the nature of the activity or occurrence reported and the agency that received the maltreatment report.

E. Additional reporting requirements for emergency use of manual restraint (EUMR)
   Follow the EUMR Policy.

REVIEWING PROCEDURE:

A. Conducting a review of incidents and emergencies
   Robland will complete a review of all incidents.
   1. The review will be completed by the Designated Coordinator.
   2. The review will be completed within 2 business days of the incident.
   3. The review will ensure that the written report provides a written summary of the incident.
   4. The review will identify trends or patterns, if any, and determine if corrective action is needed.
   5. When corrective action is needed, a staff person will be assigned to take the corrective action within a specified time period.
   6. All reviews will be submitted to the Program Director, within 24 hours of completed review by the Designated Coordinator.

B. Conducting an internal review of deaths and serious injuries

C. Robland will conduct an internal review of all deaths and serious injuries that occurred while services were being provided if they were not reported as alleged or suspected maltreatment. (Refer to the Vulnerable Adults Maltreatment Reporting and Internal Review Policy and Maltreatment of Minors Reporting and Internal Review Policy when alleged or suspected maltreatment has been reported.)
   1. The review will be completed by the Designated Coordinator and submitted to the Program Director upon completion.
   2. The review will be completed within 2 business days of the death or serious injury.
   3. The internal review must include an evaluation of whether:
      a. related policies and procedures were followed;
      b. the policies and procedures were adequate;
      c. there is need for additional staff training;
      d. the reported event is similar to past events with the persons or the services involved to identify incident patterns; and
      e. there is need for corrective action by Robland to protect the health and safety of the persons receiving services and to reduce future occurrences.

5. Based on the results of the internal review, Robland must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the program, if any.
6. The internal review of all incidents of emergency use of manual restraints must be completed according to the requirements in Robland's emergency use of manual restraints policy.

D. Conducting an internal review of maltreatment
Follow the Maltreatment of Minors or Vulnerable Adult Reporting Policy

E. Conducting a review of emergency use of manual restraints
Follow the EUMR Policy.

RECORD KEEPING PROCEDURE:

A. The review of an incident will be documented on the incident reporting form and will include identifying trends or patterns and corrective action if needed.
B. Incident reports will be maintained in the person's record. The record must be uniform and legible.

PERSON-CENTEREDNESS

Every home and community-based services program licensed under chapter 245D is required to provide services in response to each person's identified needs, interests, preferences, and desired outcomes as specified in the coordinated service and support plan and the coordinated service and support plan addendum, and in compliance with the requirements of the 245D Home and Community- Based Services (HCBS) Standards.

As required in section 245D.07, subdivision 1a of the 245D HCBS Standards, 245D licensed programs must provide services in a manner that supports each person's preferences, daily needs, and activities and accomplishment of the person's personal goals and service outcomes, consistent with the principles of:

Person-centered service planning and delivery that:

- identifies and supports what is important to the person as well as what is important for the person, including preferences for when, how, and by whom direct support service is provided;
- uses that information to identify outcomes the person desires; and
- respects each person's history, dignity, and cultural background;

Self-determination that supports and provides:

- opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and
- the affirmation and protection of each person's civil and legal rights; and

Providing the most integrated setting and inclusive service delivery that supports, promotes & allows:

- inclusion and participation in the person's community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible and supports the person in developing and maintaining a role as a valued community member;
- opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports; and
- a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety, or rights.

The following questions can be used by persons receiving services licensed under chapter 245D to help identify how they want services provided to them. It is recommended that the support team or extended support team discuss these questions together when completing service assessments, planning, and evaluation activities to help ensure the goals of person-centered planning and service delivery are met for each person served.

Sample of Person-Centered Planning and Service Delivery Questions for Initial Planning:

- What are your goals for service outcomes?
- What are your preferences related to?
    a. Time you wake up in the morning and go to bed at night?
    b. What your favorite foods are?
    c. What are foods you don't like?
    d. Whom you prefer to have direct support service provided from?
- Do you take any medications?
- Do you need help with your medications?
- What are some of your interests?
- Do you have any hobbies?
- What are things you like to do in the community?
- Is there an activity or skill that you would like to learn?
- Do you have any special relationships?
- Do you work in the community?

Sample of Person-Centered Planning and Service Delivery Questions for Program Evaluation and Progress Review:

- Do you feel your relationships are supported by staff?
- What do you like about your home?
- Is there anything that bothers you about your home?
- Do you like the people you live with?
- Do you feel the house you live in is safe?
- Do you feel any rules in your house are unfair?
- Do you have a private place to go to at home?
- Do you have goals to meet at home?
- Do you want to work?
- Is there anything that bothers you at work?
- Do you feel that staff treats you with dignity and respect?
- Do you feel that your privacy is respected?
- Do you feel that decisions you make are respected?
- Do you feel that you are given the opportunity to be as independent as possible?

You or your support team may think of other questions that are important to you. You should feel free to discuss these questions with your service provider.

People with disability labels have been excluded from the mainstream of society for centuries. Because of this lack of access to and involvement in community life, the value of certain groups of people has not been fully realized. Person-Centered Planning attempts to identify and highlight the unique talents, gifts and capabilities inherent in everyone. Explore and discover where in the "real" world these gifts can be shared and appreciated and where the person's contributions and social roles will be valued.

Person-Centeredness focuses on the desires and abilities of the individual. It involves a team of family members, friends, and professionals as well as the participant. Team members are chosen by the individual. This team identifies skills and abilities of the person that can help achieve goals of competitive employment, independent living, continuing education and full inclusion in the community. This also helps to identify areas where the individual may need assistance and support, and the team helps to decide how to meet those needs.

Traditional planning methods view individuals with disabilities as "deficient" and unable to contribute to the community. This way of thinking invites discrimination, ridicule, and abuse. This ideal focuses on deficits, perceived lack of skills or talents. Goals in the traditional method are centered on "fixing" the individual. These goals focus on the negative and encourage institutionalization of people with disabilities. This works from the theory that people with disabilities are not qualified to decide for themselves how they want to spend their lives and is contrary to values of freedom and liberty.

PERSON CENTERED PLANNING	TRADITIONAL METHOD PLANNING
Focus is on the person	Focus is on the program standards
Changes in services based on the person's needs/wants	Changes in service based on the organization's decisions
Program designed for the person	Person is assigned to the program
Performance expectations are defined by the person	Performance expectations are defined by the program

In a real Person-Centered plan, the participant sets the agenda, chooses the team, the team works on the individual's agenda with measurable accomplishments and the team celebrates those accomplishments. This plan is about the individual's life. A ***false*** Person-Centered plan team only meets once a year, the planners here are mainly professionals, the program drives the plan, nothing seems to change, the meetings are a drudge and the plan is about a document.

PERSONAL OUTCOMES

Personal outcomes are goals that we set for ourselves; they are defined from the person's perspective. These are often items that each of us individually identify as important to us and are the standards by which we measure the quality of our life. These are individual and vary from person to person. Personal outcomes have no standard definition, there is no "right" answer. The agency and staff should not only provide individuals with needed supports, but should also help the them develop natural supports in the community that will assist them in reaching their personal outcomes. None of us reach our personal outcomes without support from others like family and close friends.

Personal outcome measures are grouped into three factors:

- Myself (who I am as a result of my unique heredity, life experiences, and decisions)
- My world (where I work, live, socialize, belong, and connect)
- My dreams (how I want my life to be)

People who choose personal outcomes choose personal goals, including where and whom they live with, where they work, etc. These individuals have intimate relationships, they are satisfied with their services, and they are satisfied with their personal life situations as well. Personal outcomes help individuals choose their daily routines, allow them to have time and space for privacy, decide when to share their personal information, how to use their environments, and are safely connected to natural support networks. Often these people live in integrated environments, they participate in the life of the community, they interact with other members of the community, perform different social roles, they have friends, and are respected.

Personal outcomes put listening to and learning from the participant at the center of each conversation. Personal outcomes provide a guide to person-directed planning and enable agencies to identify the individual's priorities. These priorities direct planning efforts, based off of the individual's own experiences, and reinforce diversity. The agency should provide the needed supports after the participant defines their outcomes.

Within the outcome planning, team members must gather information in order to understand the participant's vision and develop action plans that will allow for them to implement their elements, evaluate their effectiveness, and refine plans as needed to increase success.

Good planning is tailored to the dreams, goals, and needs of the participant and results in real actions and outcomes for that individual. These plans build and sustain relationships and the team works together to solve problems and assist the individual in building a more desirable future. Understanding the person's vision is the most important step in planning and may require creativity and investment. This doesn't stop with the assessment planning process. In planning, the participant must direct the action – this is non-negotiable – and the vision for the individual must come from the person and their life experiences. In planning, the participant works as a partner with service personnel to ensure that staff understand their desires and needs, then a plan is built around the individual's vision for their life.

Self-determination plays an important role in Person-Centeredness. Self-determination is a strong voice for and by persons with disabilities, promoting independence, empowerment, leading by example, communicating, networking, and encouraging each other. It's all about individuals making their own personal choices. Choice making decreases behavioral concerns because people are motivated to live the type of lifestyle that they want. Choice making is a balance between risk taking, support, and safety. Through choice making we not only provide the individual with the opportunity to create greater self-control, but we also teach them to select preferred options and teach them how to communicate clearly. People experiencing self-determination take risks, make mistakes, learn what they like and dislike, learn what they want and need, learn to communicate, make decisions, and work towards achieving the life that they prefer.

Who?

- Who are you?
- How do you define yourself as a human being?
- When you go through your day how do you view, classify, and attempt to define others?

When…

- When you see an individual in a wheelchair what do you see first?
  - The wheelchair?
  - The physical issue?
  - The person?

It is how you say it…

- If you saw a person in a wheelchair unable to get up the stairs into a building, what would you say?
  - "…there is a handicapped person unable to find a ramp."
  - "…there is a person with a disability who is handicapped by an inaccessible building."
  - To you, which is the proper way to speak about someone in that situation?

"Hi, how are you?"

How do you go about introducing someone who doesn't have a disability. You would give their name, maybe where they live, what that person is or is not interested in such as video games, eating Mexican food, swimming, reading, etc.

We look to define people like we would like to be defined.

"Hi, how are you?"

Why would we speak differently in our introduction of someone with a disability? We are all made up of many varied and different characteristics, both mental & physical. Most people would not want to be identified by a singular description like their love of garlic, their inability to kayak, or the color of their hair. They are just parts of who we are, not the total.

"Hi, how are you?"

When speaking or writing remember we are more alike than different with the clients we serve. When you engage with people with disabilities keep that mind.

Person First Language

- Speak to the person first, not to the disability.
- Emphasize abilities, not limitations
- Do not label people as part of a disability group. Don't say "The Disabled", instead say "People with disabilities".
- Don't give excessive praise or attention to a person with a disability & don't patronize.

Person First Language

- Choice & independence are important; let the person do or speak for themselves as much as possible. If addressing an adult speak to them as you would an adult, i.e. say 'Bill' not 'Billy'.
- A disability is a functional limitation that interferes with a person's ability to walk, hear, talk, learn, etc.; use handicap to describe a situation or barrier imposed by society, the environment, or oneself.

Person First Language

Say...	Instead of...
• Child with a disability	• Disabled or handicapped child
• Person with cerebral palsy	• Palsied, or CP, or spastic
• Person who is deaf or hard of hearing	• Deaf and dumb
• Person with retardation	• Retarded
• Person with epilepsy or person with a seizure disorder	• Epileptic
• Person who has...	• Afflicted, suffers from, victim

Person First Language

Say…	Instead of…
• Without speech, nonverbal	• Mute or dumb
• Developmental delay	• Slow
• Emotional disorder or mental illness	• Crazy or insane
• Uses a wheelchair	• Confined to a wheelchair
• With Down Syndrome	• Mongoloid
• Has a learning disability	• Is learning disabled
• Nondisabled	• Normal, healthy

Person First Language

Say…	Instead of…
• Has a physical disability	• Crippled
• Congenital disability	• Birth defect
• Condition	• Disease (Unless it is an actual disease)
• Seizures	• Fits
• Cleft Lip	• Hare lip
• Mobility impaired	• Lame
• Medically involved, or has a chronic illness	• Sickly

Person First Language

Say…	Instead of…
• Paralyzed	• Invalid or paralytic
• Has hemiplegia (Paralysis of 1 side of the body)	• Hemiplegic
• Has quadriplegia (Paralysis of both arms & legs	• Quadriplegic
• Has paraplegia (Loss of function in lower body only)	• Paraplegic
• Of short stature	• Dwarf of midget
• Accessible parking	• Handicapped parking

World Health Organization Definitions

- **Impairment** – The absence or deficiency of a specific structure or physiological function. This is a physical reality, a disease or diagnosis.

World Health Organization Definitions

- **Disability** – The limitation of one's ability to engage in activities or perform skills, as a result of an impairment. This is a limitation in adaptive skill areas.

World Health Organization Definitions

- **Handicap** – The negative impact of a disability on an individuals' ability to participate in mainstreamed society. It results from the inability of society to accommodate the needs of people with disabilities.

Different Drums & Different Drummers

- If I do not want what you want, please try not to tell me that my want is wrong.
- Or if I believe other than you, at least pause before you correct my view.
- Or, if my emotion is less than yours, or more, given the same circumstances, try not to ask me to feel more strongly or weakly.

Different Drums & Different Drummers

- I do not, for the moment at least, ask you to understand me. That will come only when you are willing to give up changing me into a copy of you.
- I may be your spouse, your parent your off

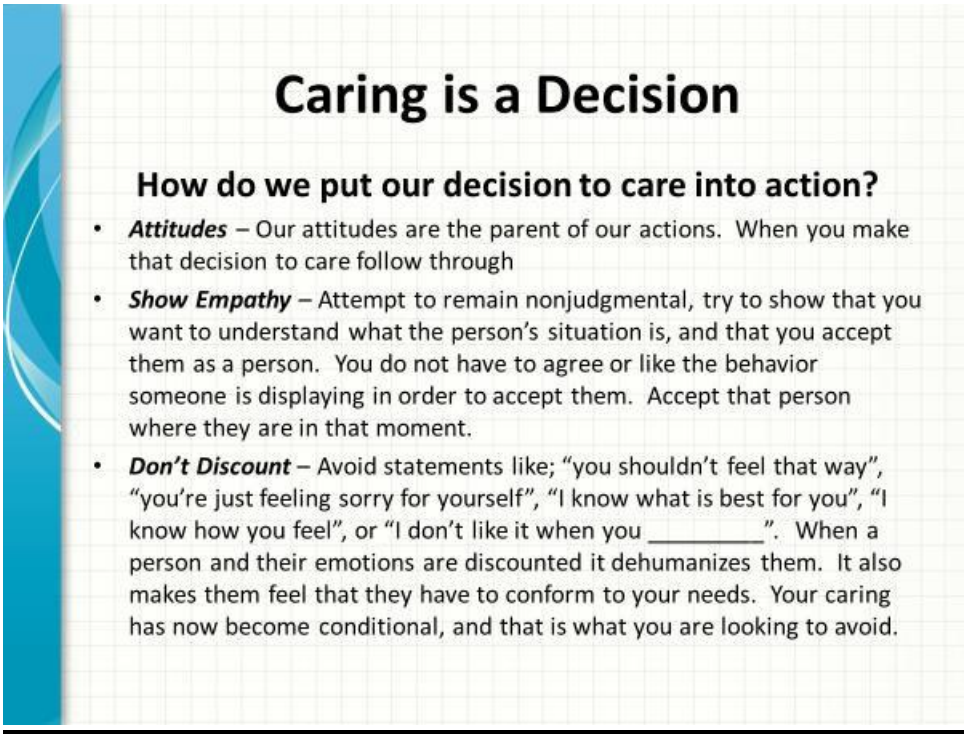
Different Drums & Different Drummers

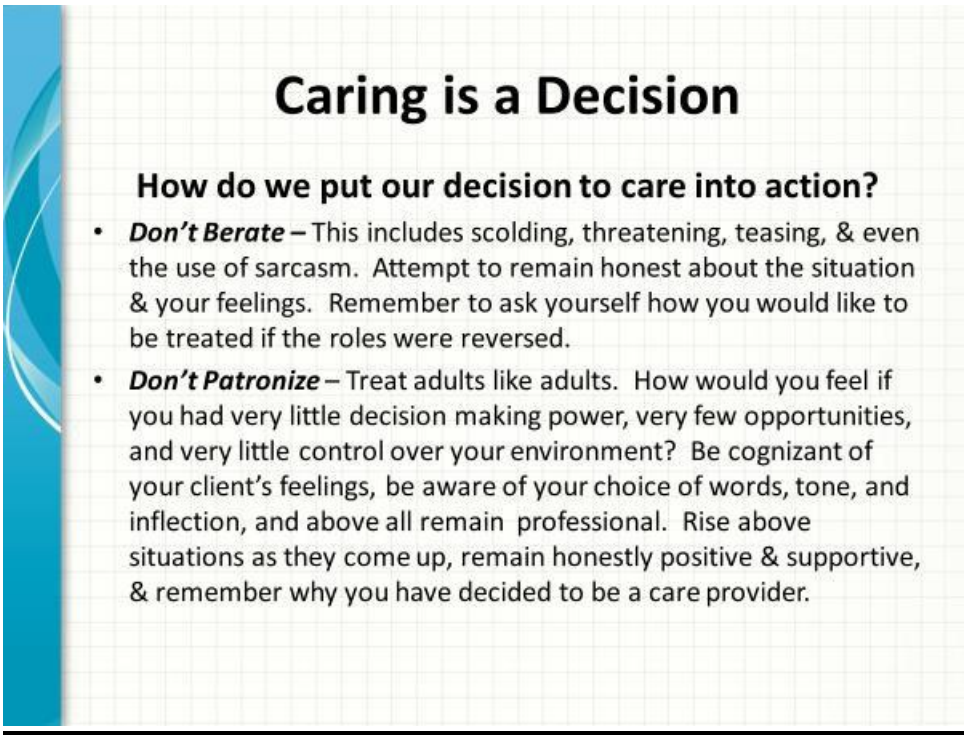
- I may be your spouse, your parent, your offspring, your friend, or your colleague. If you will allow me any of my own wants, or emotions, or beliefs, or actions, then you open yourself, so that some day these ways of mine might not seem so wrong, & might finally appear to you as right – for me.

Different Drums & Different Drummers

- To put up with me is the first step to understanding me. Not that you embrace my ways as right for you, but that you are no longer irritated or disappointed with me for my seeming waywardness. And in understanding me you might come to prize my differences from you, &, far from seeking to change me, preserve & even nurture those differences.*

* From: '*Please, Understand Me*', by David Keirsey & Marilyn Bates


Caring is a Decision
How do we put our decision to care into action?
• Attitudes – Our attitudes are the parent of our actions. When you make that decision to care follow through
• Show Empathy – Attempt to remain nonjudgmental, try to show that you want to understand what the person's situation is, and that you accept them as a person. You do not have to agree or like the behavior someone is displaying in order to accept them. Accept that person where they are in that moment.
• Don't Discount – Avoid statements like; "you shouldn't feel that way", "you're just feeling sorry for yourself", "I know what is best for you", "I know how you feel", or "I don't like it when you _____". When a person and their emotions are discounted it dehumanizes them. It also makes them feel that they have to conform to your needs. Your caring has now become conditional, and that is what you are looking to avoid.


Caring is a Decision
How do we put our decision to care into action?
• Don't Berate – This includes scolding, threatening, teasing, & even the use of sarcasm. Attempt to remain honest about the situation & your feelings. Remember to ask yourself how you would like to be treated if the roles were reversed.
• Don't Patronize – Treat adults like adults. How would you feel if you had very little decision making power, very few opportunities, and very little control over your environment? Be cognizant of your client's feelings, be aware of your choice of words, tone, and inflection, and above all remain professional. Rise above situations as they come up, remain honestly positive & supportive, & remember why you have decided to be a care provider.

Caring is a Decision

How do we put our decision to care into action?

- ***Don't Personalize*** – Realize the situation for what it is. Don't let your anger, frustration, or other negative emotions dictate your decisions or actions. If you feel that you are losing objectivity take a break, regroup, & afterwards talk to someone about it. Questioning yourself, having negative emotions, & even being frustrated are not signs of weakness. We lose no credibility in being professional and accountable for our feelings & thoughts. Remember to attempt to keep the needs & care for your consumers as your primary concern.

Remember….

- See the person first. Recognize that we all have distinct differences, attributes, & abilities. Think about how you would want others to see you, & do the same courtesy to others
- Think before you speak. Your words have power. Once something is said or done it can't be taken back. Be deliberate in your thoughts, words, & deeds.
- We are more alike than different. The issues that you as a caregiver struggle with; relationships, finances, work, transportation, etc. are the same issues the people we serve struggle with. Be empathetic to their struggle as you would anyone else.
- When in doubt ask yourself if this is how you would like to be treated or how you would like a family member treated. If the answer is 'No' then rethink your statement, your decision, or your tactics.

EMERGENCY USE OF MANUAL RESTRAINTS (EUMR)

The goal of this training is not to teach you self-defense skills, but to increase your confidence and competence in the agency requirements for physical contact with clients. It is incredibly important that you do NOT have physical contact with a client in any way unless it is written into their Support Plan due to disability. We are not to ever utilize restraints of any kind to change a client's behavior, unless our client's life is in immediate physical danger if we do not intervene. This training will allow you to establish a quality relationship with those that you serve, help you to set appropriate boundaries, and recognize the correlation between "I don't know" and "I don't care". Consistency, communication, and training are the building blocks of optimizing and maintaining both confidence and competence.

What is a behavior? In short, a behavior can be defined as "anything observable". Behavior is a function of communication, a reaction to a stimulus (or lack of stimulus), and it is the manifestation of a feeling or emotion. Individuals with development disabilities, mental illnesses, and/or brain injuries may experience a biological impact on their behaviors and decision making due to their diagnoses.

"GO" Brain v. "STOP" Brain	
PREFRONTAL CORTEX	**AMYGDALA**
Differentiate among conflicting thoughts	Formation & storage of emotional memories
Determines "good" and "bad"	Modulation of memory consolidation
Determines future consequences of current choices	Controls automatic responses associated with fear
Works towards a defined goal	Controls the ability to perceive other's emotions
Suppresses urges	Controls the ability to feel emotions
Identifies "better" and "best", "same" and "different"	Secretes hormones

THE ART OF CONCLICT RESOLUTION

Conflict will arise any time two people have different ideas or opinions on the same matter. Conflict doesn't have to be a negative or stressful experience, it can be a space where learning happens and both parties remain respected and heard. In conflict resolution, there are some key things to remember:

- You cannot make anyone do anything, so don't set your goal at forcing someone to do what you wish
- Ask yourself what purpose this conflict serves in the grand scheme of things to determine if it is necessary
- Put aside your need to "be right" and to "have the last word" as this will not create an

environment of respect
- Validate the emotions of others in the conflict and explain your emotions in order to have them validated
- Identify the difference between "wants" and "needs" to see what may be an option for compromise

There are three players in any confrontation. **You** are the first player. It's important to understand what your limitations are in the context of this conflict, what role you're fulfilling in this conflict, and what non-verbal messages you are sending in order to help determine if this is worth a confrontation at all. **The Other Person** is also a player in every conflict. What limitations does the other person have in the context of this conflict? Have they identified what they want or need from this situation, and are their emotions being validated? It's important to always make sure that there are no immediate safety concerns for the other person, and examine what alternatives and tactics have already been attempted in order to solve this problem. The last player in every conflict is **The Environment**. The environment may pose limitations or issues of safety. Be sure to give and respect space during a confrontation.

STOP. THINK. THEN ACT.
Self-control and deliberate thinking are the keys to conflict resolution. If we can control our physiological reactions, both the autonomic and the idiosyncratic, we are more likely to maintain control over the situation. In order to exhibit control over this and encourage deliberate thinking, we must identify our own feelings and learn to compartmentalize them. Once this is done (quickly), it's important to interpret the provoking event accurately – why is this occurring now? Generate alternative responses to the situation and then choose the most useful response – not for you or the other person, but for the situation as a whole. Implement your chosen response with full freedom, but remain flexible in thought.

When anyone perceives a threat, they have an initial chemical response that runs through their brain. The object of conflict resolution is to respond rationally when a threat is perceived. When doing this successfully, the mind goes through four stages:

1. Stage 1: Awareness of the threat that is posed or made
2. Stage 2: Resolution within yourself of "fear" or "denial" of threat
3. Stage 3: Consultation with all other parties involved in the conflict
4. Sage 4: Decision, which leads to final resolution

Remember that stress, anxiety, negative emotions, and your own control issues are the enemy of deliberate thought. The people that you serve are counting on you to think things through, react compassionately, act as a professional, and keep their safety and well-being in mind. We can do this by going through the steps in the Assessment Cycle, as listed below.

This cycle allows us time to reflect on decisions made within a conflict and assess whether or not the plan should be changed based on our outcomes. It is important to remember that conflicts don't end once a plan is implemented. A plan must be assessed and revised as needed in order to achieve success. Remember to use tactics that help limit safety concerns and risks and know that **THE USE OF RESTRAINT IS A LAST RESORT** and can only be used during life-threating situations, *not* to modify unwanted behaviors.

There is a "Scale of Alternatives" when it comes to physical restraint. At the bottom of this scale, you could choose to do nothing. At the next phase you could offer non-verbal cues that the consumer should change their behavior (such as disengaging from the conversation). Still next you could offer a verbal non-directive (such as asking if they are aware of their surroundings) or move to the next level of verbal direction. After verbal direction it may be appropriate to use touch in the form of tapping someone on the shoulder, but chances are at this point safety is paramount and you would move to the top of the scale, which is using a Simple Escort to physically redirect the individual, which is known as a "restraint" even though a Simple Escort calls us to let go as soon as the redirection occurs. *If a Simple Escort is ever used during care provision, make your supervisor aware immediately.*

Verbal de-escalation tactics are often the most successful ways to reduce conflict. Some tactics of this are:

- Questioning
- Non-verbal recognition
- Listening
- Bridge of commonality
- Re-focusing
- Changing the subject
- Offering alternative options
- Use of humor
- Motivation
- Empathizing
- Brainstorming solutions
- Setting limits
- Stating of potential natural outcomes
- Distraction
- Visual learning tools

With all that you've developed over time and all that you've learned throughout this training packet, we are confident that you will be successful with eliminating the need for Emergency Use of Manual Restraints, and that if the need were to ever arise, you would act appropriately and report the scene swiftly

Strategies and techniques used include but are not limited to:

A. *Non-Verbal recognition*
B. *Bridge of Commonality*
C. *Offer alternative solutions*
D. *Questioning*
E. *Use of humor*
F. *Distraction*
G. *Statement of Potential Natural Outcomes*

245D HOME AND COMMUNITY-BASED SERVICES EMERGENCY USE OF MANUAL RESTRAINTS (EUMR) POLICY

POLICY:

It is the policy of Robland Home Health 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.

POSITIVE SUPPORT STRATEGIES AND TECHNIQUES INVOLVED:

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:

B. Robland 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.

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 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 of 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. 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 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 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; or
   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 [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 in and of themselves constitute the use of mechanical restraint.

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 Robland:

1. Chemical restraint
2. Mechanical restraint
3. Manual restraint
4. Time out
5. Seclusion
6. Any aversive or deprivation procedure

MANUAL RESTRAINTS ALLOWED IN EMERGENCIES:

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

Alliance instructs on and allows the use of: Simple Escort

B. Robland 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.

CONDITIONS FOR EUMR:

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:
   5. the person is engaging in property destruction that **does not** cause imminent risk of physical harm;
   6. the person is engaging in verbal aggression with staff or others; or
   7. a person's refusal to receive or participate in treatment or programming.

RESTRICTIONS WHEN IMPLEMENTING EUMR:

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 with an adult in a manner that constitutes abuse or neglect;
3. be implemented in a manner that violates a person's rights and protection;
4. be implemented in a manner that is medically or psychologically contraindicated for a person;
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;
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 as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by this program;
9. use prone restraint. "Prone restraint" means use of manual restraint that places a person in a face-down position. It 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 or supine (meaning a face-up) position.

MONITORING EUMR:

A. Robland 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 Commissioner, must be completed for each incident involving the emergency use of a manual restraint.

REPORTING EUMR:

1. 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.

2. 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
    3. 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 implement. 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.

3. A copy of this report must be maintained in the person's service recipient record.

4. 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.

INTERNAL REVIEW OF EUMR:

A. Within 5 business days after the date of the emergency use of a manual restraint, Robland 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, Robland 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. Robland has identified the following person or position responsible for conducting the internal review and for ensuring that corrective action is taken, when determined necessary:

Program Director

EXPANDED SUPPORT TEAM REVIEW OF EUMR:

A. Within 5 working days after the completion of the internal review, Robland 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 must maintain a written summary of the expanded support team's discussion and decisions in the person's service recipient record.

C. Robland 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 Director

EXTERNAL REVIEW AND REPORTING OF EUMR:

Within 5 working days after the completion of the expanded support team review, Robland must submit the following to the Department of Human Services using the online reporting tool and 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.

STAFF TRAINING:

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

A. The program 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 Robland, 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 Robland 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.

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

PROHIBITED PROCEDURES AND BEHAVIOR MODIFICATION

Although the prohibited physical procedures are covered in the EUMR portion of this training packet, we will go over other prohibited procedures in this portion, such as why we don't say "no" or "you can't" to our participants. This is all part of the way that we systematically assist our clients through the use of structured Behavior Modification.

DEFINING BEHAVIOR

In order to discuss Behavior Modification, we must first define the word "behavior". For the purpose of working at Robland, the word "behavior" is defined as "anything observable". Often times we associate the word behavior with negative actions – fighting, swearing, etc. – but the truth is that behavior can be positive, negative, or neutral.

+ - OR /

Let's take an example of a seemingly neutral behavior like sleeping. Sleeping is not something many would think of as a behavior, but it is something observable, so it is. It would be easy to say that sleeping is such a passive thing to do that it is a neutral behavior all of the time, but it's important to remember the role that context plays in behaviors. If a student is sleeping through class is that neutral? No, in this case the behavior of sleeping would be negative. If someone who normally doesn't go to sleep on time due to insomnia or poor planning finally goes to sleep at a decent hour, would that be neutral? No, in this case the behavior of sleeping would be positive. With this example it's clear that managing behaviors isn't as easy as it may seem.

FUNCTIONS OF BEHAVIOR

When a check engine light comes on in a car, we know that ignoring the problem will only lead to larger problems down the road, so we take the car into a mechanic. At the mechanic's, they don't just say "the last time this car was here it needed an oil change, so it must need an oil change again" and change the oil. No – they run a diagnostic to figure out what's wrong with the car to be sure that they are fixing the right part of it. That's what we, as staff, need to do whenever we notice a "problem" that our client(s) are experiencing. If we ignore it, it will get worse. If we "fix" the wrong thing because we assumed we knew what it was instead of taking the time to figure out what it was, it will get worse. It's only when we stop, think it through, and really determine what is causing the behavior before we can figure out the best working plan to help modify it.

The "function" of a behavior is the "why" for that behavior. Finding out functions is like running a diagnostic. It helps us to answer the question, "Why did this person feel that they needed to behave in that way?" We will discuss six functions of human behavior using the following acronym:

Skill Deficit *(they've never been taught or don't remember how to do something correctly)*

Power Play *(they thrive on engaging others in a power struggle – they enjoy the fight and egg it on)*

Attention Seeking *(they believe that negative attention is better than no attention at all)*

Counter Control *(they feel like they need to quietly prove to themselves that they can control something)*

Escape & Avoidance *(they'll do what it takes to get out of an unpleasant task or situation)*

Self-Stimulation *(they're bored/frustrated and find this behavior entertaining/cathartic)*

Using these functions, the first thing that we need to do when we witness a behavior is ask ourselves *why* this behavior occurred. Was the person self-stimulating? Were they trying to seek your attention? Or is it a skill deficit – do they just not know a better way to do that? Figuring out why someone has done something involves taking into consideration the context of the scenario, the usual behaviors of the individual, and the circumstances that led up to the behavior occurring. In order to do this, we must first pin-point the exact behavior that we're "diagnosing".

Say your participant is angry that they ran out of money and can't afford to purchase any more cigarettes. While they are discussing this frustration, they lash out and push over a chair. In all of this you likely observed many behaviors, which one would you try and figure out first? The lack of budgeting? The habit of smoking? Chances are you'll pick the most immediately negative behavior – the pushing over of a chair.

In this scenario you'd go through each of the six functions of behavior and decide what category this behavior falls under. Chances are it is *not* Escape and Avoidance (they aren't trying to get out of doing anything). Chances are it is *not* Attention Seeking (they would be just as frustrated at not having smokes if they didn't have an audience). Chances are it is *not* a Power Play (they don't want a fight – they want cigarettes). Chances are it is not Counter Control (they aren't trying to control the chair by pushing it over). This leaves us with Skill Deficit and Self-Stimulation. Have you ever seen them get angry or frustrated and not push a chair over? If so, this would tell us that they know how to manage their frustration in a non-physical way – so it's likely not a Skill Deficit. Which leads us to believe it is an act of Self-Stimulation. Chances are that they were so frustrated in that moment they felt the need to physically stimulate their senses by pushing over a chair. Now that we know why something happened, what do we do about it?

3 Ways to Decrease Negative Behavior

Natural Outcomes *are the unplanned, unforced, natural results of a behavior*
Teaching Foresight *is the ability to teach others to predict the future outcomes of a current situation based on similar past situations*
Neutral Interaction *is the therapeutic act of ignoring a specified behavior, then re-engaging once the specified behavior stops*

3 Ways to Increase Positive Behavior

Skill Building *is the structured and repetitive way that we increase knowledge*
Verbal Praise *is individually specific and always includes the behavior being praised and the way that it benefitted the individual exhibiting the behavior*
Rewards *are reinforcers for behaviors such as monetary rewards and/or attention contingent on what that individual finds rewarding*

In the scenario we used before, with the pushing over of the chair, let's walk through each step above. The Natural Outcome of pushing over a chair might be what? The chair breaks then that individual doesn't have a chair anymore. Or maybe it's someone else's chair and now that person won't let this individual use their things anymore. Or maybe you were in public and the business owner asked you to leave the establishment when the chair was pushed over. These are natural – meaning we as staff do not make these results happen. It would not be a Natural Outcome for staff to take away the chair.
Did they push a chair over before and the chair broke? Teaching Foresight would look like us, as staff, saying, "What happened the last time you pushed over a chair? Do you remember that your desk chair broke that way? Do you think that this chair might break too? Is there another way that we can get this emotion out that wouldn't break things?" (Neutral Interaction would not be used in this situation as it's only for Attention Seeking and Power Play behaviors.)

On the flip side, once the person is calm, we would discuss different ways to manage frustration that don't involve breaking things. We would Skill Build new choices like working out, punching a pillow, playing music, taking deep breaths, etc. Whenever we notice this individual using one of these new skills, we would Verbally Praise them in a way that ties together the behavior and the benefit (e.g. "You put your headphones on when you were frustrated with your dinner choices, now you were able to calm down quickly and enjoy the rest of your evening!"). Remember that verbal praise is not a compliment – it ties together cause and effect. Lastly, we would Reward the use of these new coping skills contingent on the individual. If they enjoy interaction, perhaps we would reward them by going for a walk and giving them 1:1 undivided attention. If they are more introverted, perhaps we would reward them by not bothering them with interaction for a greater amount of time than usual.

When we place all of these steps together, we can ensure a positive experience for our participants when managing behaviors. It is important that we follow Behavior Modification as trained; otherwise it tends to feel like a parental model that is inappropriate for use with adults. In a parental model there would be punishments and consequences, and it overtly places yourself in a position of control over the individuals. It's important that we allow our participants to retain as much control over themselves and their lives as much as possible. Behavior Modification allows us to do just this and provides us with teachable opportunities for them.

BASIC FIRST AID

Accidents happen anywhere and anytime. Often times, first aid given at the scene can improve the victim's chances of survival and a good recovery. Any response, even if it is wrong, is better than none at all. ***Keep in mind that when in doubt as to the severity of the injuries call 911 immediately.***

Shock

Shock can kill if it is not treated quickly. Even if an injury doesn't directly cause death, a victim can go into shock and die. Shock occurs when the body's heart and brain do not get enough blood or oxygen. Some of the symptoms of shock are a pale or bluish skin or ashen color that is cold to the touch, vomiting, dull and sunken eyes, and unusual thirst. Shock requires medical treatment to be reversed, so all you can do is prevent it from getting worse.

Assess for Shock

Instructions

- **STEP 1:** Is the victim confused or disoriented? If so, assume severe shock.
- **STEP 2:** Is the victim unconscious or unresponsive? If so, assume severe shock.
- **STEP 3:** If none of the above signs of severe shock are confirmed, check for earlier stages of shock using the following steps.

Tips & Warnings

- Shock kills! Treat every injured person immediately for shock, regardless of whether or not they are exhibiting signs and symptoms.
- Wilderness treatment of shock is limited, and a person in shock can spiral downward fast! Seek professional medical care if an injured person exhibits any of the signs and symptoms of shock. Evacuate immediately.

Types of Wounds

Name	Description
Avulsions	A portion of skin is torn. This can be partial, creating a "skin flap." In a total avulsion, a body part is completely torn off.
Bruise	Bleeding that occurs under the skin causes discoloration. The area begins as red but may turn into a "black and blue mark."
Laceration	A split in the skin caused by an object. A laceration can have either a jagged or smooth edge.

Puncture	A puncture wound is caused when a sharp object pierces the skin. Included in this category are gunshot wounds, impaled objects, and an object that passes through a part of the body.
Abrasion	An abrasion is a generally a surface wound and occurs when skin is rubbed or scraped away.

Caring for a Minor Open Wound

- Stop the bleeding by applying pressure with gauze or a clean cloth.
- If the blood soaks through, apply a second bandage on top. Don't take off the first bandage as it will disturb the clotting that has already taken place.
- If bleeding still doesn't stop, raise the wound above heart level.
- Once bleeding stops, clean the wound gently with soap and water.
- DO NOT apply any ointment that you do not have a doctor's prescription for the ointment AND are trained through Robland to administer medications.
- Wrap the wound firmly in a cloth or a bandage. Do not cut off circulation!

Caring for a Major Open Wound

- Cover the wound with a clean dressing, press against it firmly with your hand.
- Elevate the wound above the level of the heart.
- Squeeze the area at a pressure point to push the artery against the bone. This is in the bottom upper arm, or where the leg bends at the hip.
- Have someone call EMS immediately.

Special Problems

When part of the body has been torn off...

- Try to find the part
- Wrap it in a clean dressing and place in a plastic bag. DO NOT CLEAN IT.
- Put the bag on ice, but don't freeze.
- Take the part to the hospital.

When an object is impaled in a wound...

- Do not remove it. You could reveal an open artery, which would then be awfully hard to deal with, a.k.a. nearly impossible.
- Bandage many dressings around the object to immobilize it and support it in its position in the wound.

Nosebleeds...

- Have the victim sit with his or her head tilted forward while pinching the nostrils together.
- Place an ice pack on the nose.

If a tooth is knocked out...

- Place gauze in the gap left by the tooth that was knocked out.
- Pick up the tooth *not* by the root, but by the crown. Place it in milk or water and DO NOT attempt to clean it.
- Seek emergency help.

The most important things to remember are the signs of major damage:

- IF the victim is in severe pain or discomfort or you suspect serious damage, ***CALL 911.***
- IF you cannot control the bleeding effectively, ***CALL 911.***
- IF you cannot wash all of the debris out of the wound, ***CALL 911.***
- IF you think the wound requires stitches, ***CALL 911.***
- If you see any of the signs of a serious infection - redness, soreness, swelling, red streaks, weeping of pus, or redness that extends more than a finger width beyond a cut, ***CALL YOUR DOCTOR IMMEDIATELY.***

Burns & Scalds

A burn can be caused by; heat, the sun, chemicals or electricity. When a burn breaks the skin, infection and loss of fluid can occur; burns can also result in difficulty breathing. If a burn victim has trouble breathing, has burns on more than one part of the body, or was burned by chemicals, an explosion, or electricity, ***CALL 911*** immediately.

Types of Burns

Superficial Burn (First Degree)

A first-degree burn involves only the top layer of skin. The skin is red and dry and usually painful. The burned area may also swell. Most sunburns are superficial burns. This type of burn usually heals in 5-6 days without any permanent scarring.

Partial-Thickness Burn (Second Degree)

CALL 911. A second-degree burn involves the top layers of skin. The skin is red with blisters. The area may also appear mottled. The burn is usually painful and often swells. This type of burn usually heals in 3-4 weeks, and scarring may occur.

Full-Thickness Burn (Third Degree)

CALL EMS. A third-degree burn destroys most or all layers of skin. The burn appears brown or black (charred) with the tissues underneath sometimes appearing white. This type of burn can be extremely painful or relatively painless if the burn destroys the nerve endings. This burn is critical and requires ***immediate*** medical attention.

Care for Burns

General Care / Thermal Burns

1. Stop the burning. Put out flames or remove the victim from the source of the burn.
2. Cool the burn. Use large amounts of cool water to cool the burn. Never use ice except on small superficial burns, because it causes body heat loss.
3. Cover the burn. Use dry, sterile dressings or a clean cloth to help prevent infection and reduce pain. Bandage loosely. Do not put any ointment on a burn. For a victim of severe burns, ***CALL 911***, lay him or her down unless he or she is having trouble breathing. Try to raise the burned areas above the level of the victim's heart if possible and protect the victim from drafts.

Chemical Burn

Call 911 in any case of a chemical burn. Remove the chemical from the skin or eyes immediately by flushing the area with large amounts of cool running water until EMS arrives. Remove any clothes with chemicals on them and be careful not to spread the chemical to other body parts or to yourself.

Electrical Burns

Call 911 in any case of an electrical burn. Do not go near the victim unless you are sure the power source has been turned off. The burn itself will not be the major problem. If the victim is unconscious, check for breathing and begin CPR if necessary. Check for other injuries, and do not move the victim because he or she may have spinal injuries. Do not cool the burn. Prevent the victim from getting chilled. There may be two wounds, one where the current entered the body and one where it left, and they may be deep.

Solar Radiation Burn

Burns caused by solar radiation may be painful and may also blister. Cool the burn. Protect the burn by staying out of the sun. If you must go in the sun, wear a sunscreen with an SPF of at least 15 and reapply it frequently. Be sure to cover up any existing sunburn if you are going to be outside again.

Broken Bones

Treat all injuries to bones, joints, ligaments, tendons, and muscles as if it was a fractured limb. For fractured limbs, take the following precautions until ***911*** arrives. Place the injured part in as natural a position as possible without causing discomfort to the patient. Use pressure and bandages to control any bleeding.

For very serious fractures involving injuries to the body, neck, or back observe the following: Do not move the victim without medical supervision, unless absolutely necessary. If a victim with a suspected neck or back injury must be moved due to an unsafe scene, keep the back, head, and neck in a straight line, preventing them from being twisted or bent during movement. Use a board or stretcher to support the victim, if available.

Spinal Injuries
Take special care when helping a spinal injury victim. All damage to the spinal cord is permanent, because nerve tissue cannot heal itself. The result of nerve damage is paralysis or death.

Do not move the limbs or body of a victim with a suspected spinal injury unless the incident scene isn't safe. The victim's body should be stabilized to prevent any movement of the head, neck or body. Be aware that any movement of a victim with spinal injury may result in paralysis or death. If the victim must be moved, keep the neck and torso of the body in the position it was found as much as possible. Do not pull the body sideways.

When providing patient care, it may be necessary to roll the victim over on his or her back to clear an airway or evaluate breathing. When rolling the victim over, the head, neck and torso should be moved together so that no twisting occurs.

Choking
Choking occurs when food or a foreign object obstructs the throat and interferes with normal breathing.

For adults and children over one year of age:
1. Ask, "Are you choking?"
2. Shout, "Help!" Call for help if the victim cannot cough, speak or breath or is coughing weakly, is making high-pitched whistling breath noises.
3. Call ***911*** for help.
4. Do abdominal thrusts: Wrap your arms around the victim's waist. Make a fist. Place the thumb side of the fist on the middle of the victim's abdomen just above the navel and well below the lower tip of the breastbone. Grasp the fist with the other hand. Press the fist into abdomen with quick inwards and upwards thrusts.
5. Repeat abdominal thrusts until the object is either ejected, EMS arrives, or the victim becomes unconscious.
6. If the victim becomes unconscious, lower the victim onto the floor and perform hands-only CPR by pumping the chest.
7. Repeat until normal breathing resumes or the ambulance arrives.

For infants one year or younger:
1. Place the victim's head in a downward position on the rescuer's forearm with the head and neck stabilized.
2. With the heel of the rescuer's hand, administer five rapid back blows between the victim's shoulder blades.
3. If the obstruction remains, turn the victim face up and rest on a firm surface.
4. Deliver five rapid thrusts over the breastbone using two fingers.
5. Repeat the above steps as necessary. If the obstruction cannot be removed, call for medical help immediately.

PREVENTION IS NO ACCIDENT

Adults:

Cut food into small pieces and chew food slowly and thoroughly. Avoid laughing and talking during chewing and avoid excessive intake of alcohol with meals

Infants and Children:

Keep marbles, beads, thumbtacks, and other small objects out of their reach and prevent them from walking, running, or playing with food or toys in their mouths

Poisoning

Simple rules of thumb:

- Call your local Poison Control Center or 911 for immediate medical attention.
- Antidotes on labels may be wrong!! Do not follow them unless instructed by Poison Control.
- Never give anything by mouth.
- If the poison is on the skin, flush skin with water for 15 minutes, then wash and rinse with soap and water.

Poisoning

A poison is a substance that causes injury or illness when it gets into a person's body. The four ways a person can be poisoned are: *ingestion* (swallowing it), *inhalation* (breathing it), *absorption* (absorbing it through the skin), and *injection* (by having it injected into the body). Ingested poisons include foods, alcohol, medication, household and garden items, and certain plants. Inhaled poisons may be gases, like carbon monoxide from car exhaust, carbon dioxide from sewers, and chlorine from a pool, or fumes from household products like glue, paint, cleaners, or drugs. Absorbed poisons enter the body through the skin; they may come from plants, fertilizers or pesticides. Injected poisons enter the body through bites or stings of insects, spiders, ticks, marine life, snakes, and other animals, or medications injected with a hypodermic needle.

Ingestion

If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. Signs of poisoning are: nausea, vomiting, diarrhea, chest or abdominal pain, difficulty breathing, changes in consciousness, seizures, or burns around the lips or tongue or on the skin. If you believe someone may have swallowed a poison, try to determine what type of poison was ingested, how much was taken, and when it was taken. If you find a container, bring it to the telephone with you when you make your emergency call. Do not give the victim anything to eat or drink unless medical professionals tell you to.

Inhalation

If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. Signs of poisoning by inhalation may include pale or bluish skin. Remove the victim from the source of the toxic fumes so he or she can get some fresh air as soon as possible.

Absorption
If you suspect that someone has been poisoned, call your Poison Control Center or EMS immediately. If poison, such as dry or wet chemicals, gets on the skin, flush the area with large amounts of water, and continue flushing the area with water until EMS arrives. If you have simply had a run-in with poison ivy, poison oak or poison sumac, there is no need to call EMS. Wash the affected area with soap and water and wash the clothing you were wearing when coming into contact with this. See a doctor if the condition gets worse, affecting large areas of the body or face.

Injection
If possible, remove stinger by scraping it off with a blunt edge (e.g. credit card). Clean wound and apply cold compress to reduce swelling. Remove tight clothing and jewelry from areas near the bite in case swelling occurs. Watch for signs of shock or allergic reaction. Signs include swelling or itching at the wound site, dizziness, nausea or difficulty breathing. Seek medical attention immediately if any of these signs occur. Continue monitoring victim for shock. Check breathing and, if impaired call 911 and begin CPR. ***IMPORTANT: only a trained & qualified person should administer CPR.***

THE ELEMENTS
Who is at risk?
People who work or exercise outdoors or indoors where the temperature is poorly regulated, elderly people, young children, people with health problems, a respiratory or cardiovascular disease or poor circulation, people who take medications to eliminate water from the body, and people who have a history of heat or cold-related illness in the past are at risk.

Heat-Related Illnesses
Heat Cramps
Heat cramps, heat exhaustion and heat stroke are the three conditions caused by overexposure to heat. Heat cramps are painful muscle spasms. They result from a combination of fluid and salt loss caused by heavy sweating. Heat cramps usually occur after strenuous exercise or work outdoors in warm temperatures. They tend to occur in the legs and the abdomen. They are an indication of a more severe problem to come if proper care is not given shortly.

Care for Heat Cramps
Have the victim rest comfortably in a cool place and provide him or her with cool water or a sports drink. Stretch the muscle gently and massage the area. Once the cramps stop, the victim may resume physical activity, but he or she should be sure to drink plenty of fluids during and after activity.

Heat Exhaustion
Heat exhaustion, the most common heat-related illness typically occurs after strenuous exercise or work in a hot environment. The victim loses fluid through sweating, and blood flow to the skin increases, thus reducing blood flow to the vital organs. The victim therefore goes into mild shock.

Symptoms of heat exhaustion are: normal or below normal body temperature; pale, moist, cool skin; headache; nausea; dizziness; weakness; and exhaustion. If heat exhaustion is allowed to progress, the victim's condition will worsen until he or she has heat stroke.

Heat Stroke

Heat stroke, the least common heat-related illness, occurs when heat exhaustion symptoms are ignored. The body systems become overwhelmed by heat. Sweating stops, and the body can no longer cool itself. Body temperature rises rapidly, and the brain and other vital organs will begin to fail. Convulsions, coma and death may result. Signs of heat stroke are: high body temperature; hot, red, dry skin; progressive loss of consciousness; rapid, weak pulse; and rapid, shallow breathing.

Care for Heat-Related Illnesses

Call 911 immediately if the victim's condition is so bad you suspect heat stroke. If heat-related illness is recognized in the early stages, it can usually be reversed. Move the victim to a cool area and give them a cold drink (not alcohol). Remove any tight or heavy clothing and cool the body however you can; apply cool, wet cloths to the skin, fan the victim, or place ice packs on the victim's wrists and ankles, in each armpit and on the neck. Don't let the victim drink too much too quickly. If the victim vomits, stop giving fluids. Continue cooling the individual until EMS arrives.

The best defense is PREVENTION.

Here are some precautions you can take…

- Wear **lightweight, light-colored loose-fitting** clothing.
- **Apply sunscreen** with a Sun Protection Factor *(SPF)* rating of at least "SPF 15" to exposed portions of the body
- **Limit exposure** during the hottest hours: 10 a.m. to 4 p.m.
- If possible, **avoid** strenuous work or exercise outside.
- **Take advantage of shade** and/or wear a **wide-brimmed hat**.
- Stay in **air-conditioned** areas or use cooling **fans** to speed sweat evaporation.
- Stay indoors and, if at all possible, stay in an air-conditioned place. If your home does not have air conditioning, go to the mall or a public library. Fans may provide comfort, but when the temperature is in the **high 90s or above**, fans **will not** prevent heat-related illness. Taking a cool shower or bath or moving to an air-conditioned place is a much better way to cool off.
- **Drink lots of cool, non-alcoholic fluids.** If you're exercising or working, drink 2 to 4 glasses of water an hour. If you lose a lot of fluid on a hot day, sports drinks are preferred over water because they will replenish sodium.

- **Don't wait until thirsty to drink.**
  Drink more fluids *(nonalcoholic)* **regardless of your activity level**.
  Don't rely upon **thirst** as an **indicator** of your need for water; it's not reliable in very high heat.

- **Don't drink** liquids that contain **caffeine**, **alcohol**, or large amounts of **sugar** —these actually cause you to lose more body fluid. Also, avoid very cold drinks, because they can cause stomach cramps.

- **Avoid hot foods** and **keep meals light** Put less fuel on your inner fires. Foods *(like proteins)* that increase metabolics also increase water loss *(the body has to work harder to digest heavy foods)*.

- **NEVER leave anyone** in a closed, parked vehicle. Certainly, **don't leave children or pets in a vehicle**, even for "a few minutes." Heat builds up rapidly to exceptionally high temperatures in a closed vehicle, and it doesn't take much exposure to make children or pets very ill.

Pay attention to warning signs:

- Red, hot sweaty skin, cramps, lightheadedness and fatigue will occur long before heatstroke.
- Get out of the heat immediately and seek medical attention.

Cold Emergencies

Frostbite

Frostbite is the freezing of body tissues. It usually occurs in exposed areas of the body, affecting superficial or deep tissues. Frostbite is quite serious. The water in and between the body's cells freezes and swells, damaging or destroying the cells. Frostbite often results in the loss of fingers, hands, arms, toes, feet, and legs. Symptoms of frostbite are: lack of feeling in the area, a waxy appearance to the skin, skin that is cold to the touch, and skin that is discolored (flushed, white, or blue).

Care for Frostbite

Handle the area very gently, and DO NOT rub the affected area. Warm the area by soaking it in water no warmer than 100-105 degrees Fahrenheit, using a thermometer to check the water temperature if possible. Leave the frostbitten area in the water until it is red and feels warm. Bandage the area with a dry, sterile dressing, placing cotton or gauze between frostbitten fingers or toes. Avoid breaking any blisters and seek medical attention as soon as possible.

Hypothermia

When hypothermia occurs, the entire body cools because its warming mechanisms fail. If proper care is not promptly administered, the victim will die. Body temperature drops
below 95 degrees Fahrenheit in hypothermia, the heartbeat becomes erratic and finally stops, and the victim dies. Symptoms of hypothermia are: shivering; a slow, irregular pulse; numbness; a glassy stare; and apathy along with decreasing levels of consciousness. People can develop hypothermia even when the temperature is only moderately cold. Elderly people in poorly heated homes, homeless or ill people, or people with certain medical conditions are more susceptible to hypothermia.

Care for Hypothermia

If you suspect a victim may have hypothermia, call 911 immediately. Care for any life-threatening problems. Remove any wet clothing, dry the victim, and warm the body gradually by wrapping the victim in blankets. Move the victim to a warm place. You can use hot water bottles or heating pads to help rewarm the body. DO NOT warm the victim too quickly, and DO NOT immerse the victim in warm water. In cases of severe hypothermia, the victim may be unconscious. Monitor the victim's breathing until EMS arrives.

Fainting

Before losing consciousness, the victim may complain of...

- Lightheadedness
- Weakness
- Nausea
- Pale and clammy skin

If a person begins to feel faint, he should...

- Lean forward
- Lower head toward knees
- If someone becomes unconscious, put them in the recovery position
- Loosen any tight clothing
- Apply cool, damp cloths to face and neck
- In most cases, the victim will regain consciousness shortly after being placed in this position.

After the victim regains consciousness, do not let him get up until you have questioned him (Who are you? Where are you? Do you know what day it is?) to be sure they have completely recovered.

Diabetic Emergency

The condition in which the body does not produce enough insulin or does not use insulin effectively is called *diabetes mellitus*.

If someone is experiencing hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar), 911 should be called immediately. If the person is conscious and able to swallow, give him or her sugar in the form of fruit juice, candy, a non-diet soft drink or table sugar, either dry or dissolved in a glass of water.

Seizures

When injury, disease, fever, poisoning, or infection disrupts normal functions of the brain, the electrical activity of the brain becomes irregular. This irregularity can cause a sudden loss of body control known as a seizure. If a person is having a seizure, protect him or her from injury. Remove nearby objects that could cause injury, especially protect the person's head. Call EMS if any of the following situations occur; the seizure lasts for more than five minutes, the person has repeated seizures without regaining consciousness, the person has other injuries, the person has diabetes or is pregnant, or the person fails to regain consciousness after a seizure.

Stroke
A stroke, also called a "brain attack", is a blockage of blood flow to a part of the brain. It can cause permanent damage to the brain if the blood flow is not restored. Sudden signals of a stroke include; weakness or numbness on one side including face or arm or leg, difficulty speaking or slurred speech, sudden dizziness, blurred vision or sudden severe headache.

For a brain attack think **F.A.S.T!**

- **F**ace – Ask the person to smile. Does one side of the face droop?
- **A**rms – Ask the person to raise both arms. Does one arm drift downward?
- **S**peech – Ask the person to repeat a simple phrase. Is their speech slurred or strange?
- **T**ime – If you observe any of these signs, call 9-1-1 immediately.

Stay with the person and monitor their breathing and other signs of life. If the person is conscious, check for non-life-threatening conditions, and if you see signals of a stroke, call ***911 IMMEDIATELY***.

Allergic Reactions
Insect bites or stings or contact with certain drugs, medications, foods, and chemicals can cause an allergic reaction. If the person is suffering a severe allergic reaction from an insect bite or sting, or from eating a certain type of food contact ***911 immediately***. The person may have a medical kit (such as a epinephrine auto-injector) to treat a severe allergic reaction known as anaphylaxis. Assist the person as needed with using the kit until help arrives.

MINIMIZING THE RISK OF SEXUAL VIOLENCE FOR PEOPLE WITH DISABILITIES

Please find below a newly required training topic from the Department of Human Services (DHS). This training does contain information and language directly related to abuse and sexual assault so please keep that in mind as you proceed through the training.

As used by the Department of Justice in the National Crime Victimization Survey (NCVS), the term "disability" includes a wide range of limitations such as sensory (vision, hearing), cognitive, self-care, and ambulatory or mobility limitations. People with disabilities may face different challenges and some disabilities may put people at higher risk for crimes like sexual assault or abuse. According to the NCVS, people with disabilities are victimized by crime at higher rates than the rest of the population.

People with disabilities are:

- 3 times more likely to experience violent victimization as adolescents and adults
- 3 times more likely to experience rape, sexual assault, aggravated assault, and/or robbery
- 3 times more likely to be sexually abused as children
- 1.6 times more likely to experience abuse or neglect as children
- 1.5 times more likely to experience repeated abuse or neglect as children

Why are so many people with disabilities abused?
A number of factors contribute to people with disabilities experiencing higher rates of domestic and sexual violence and higher recurrence rates. Along with the below list, perpetrators may perceive people with disabilities as easy targets because of societal stereotypes and extremely low rates of prosecution of perpetrators of crimes against people with disabilities. Additionally, the severe underreporting of these crimes serves to further compound the overall inability of the system to address this problem.

Commonly cited risk factors of sexual victimization for persons with disabilities include:

- Type of disability
- Negative public attitudes toward persons with disabilities that lead sex offenders to view them as easy targets and think it unlikely that their actions will result in a conviction
- Social isolation
- Communication barriers
- Lack of accessible transportation
- Reliance on others for care, assistance with personal needs and/or management of their affairs
- Learned compliance of people with disabilities
- Lack of knowledge about sexuality and/or healthy intimate relationships
- Poverty
- Lack of resources/knowledge of resources

Barriers to Seeking Help
Some examples of barriers that prevent victims with disabilities from reporting and/or seeking help include:

- **Lack of accessibility to services** (reliance on abusive caregivers to access resources, social isolation, communication barriers, etc.)
- **Situational factors** (lack of needed services, lack of information about available services, etc.)
- **Fear** of perceived consequences (retaliation by offenders, loss of independence, negative reactions by family, friends and professionals, etc.)
- **Socialization and educational factors** (e.g., socialized to be compliant and depend on others for protection, manipulated to feel blame or uneducated about sexuality)

Intervention – responding after abuse occurs — is essential.
Prevention – taking action before abuse occurs — is critical to ending abuse.

Individuals should never be blamed or held responsible for their own victimization. Increasing protective strategies for at-risk individuals has proven to be one way to help reduce the risk of victimization. Risk reduction is also the responsibility of service providers, as they can proactively identify resources and address obstacles to reporting and accessing services.

Examples of protective strategies for at-risk individuals:

- Ensure access to communication methods (phone, Internet, etc.) if help would be needed.
- Maintain access to assistive devices.
- Minimize financial dependency on one person; include more than one person in financial arrangements.
- Obtain and understand basic information on sexual violence, personal boundaries, personal safety and community resources.
- Inform caregivers and other service providers that sexual assault will be reported to law enforcement and follow through with reporting.
- Reduce isolation through multiple social connections that occur unscheduled in person or via the phone or Internet.
- Have an individualized safety plan.

Examples of ways service providers can work on a systemic level to reduce risk:

- Change policies that limit victims' access to services.
- Support local projects that increase safe, independent living opportunities for persons with disabilities.
- Encourage policies and practices that will increase the safety of individuals with disabilities, such as screening policies for personal care attendants and guardians.
- Increase awareness of the risk of sexual victimization to create a supportive social environment that encourages victims to speak out.
- Provide cross-training to all disciplines involved in the service delivery system to ensure that victims with disabilities will be well served at all points of entry into the system

The Role of Consent

Consent is crucial when any person engages in sexual activity, but it plays an even bigger, and potentially more complicated role when someone has a disability. Some disabilities may make it difficult to communicate consent to participate in sexual activity, and perpetrators may take advantage of this. People with disabilities may also not be given the same education about sexuality and consent that people without disabilities receive. In addition, someone who has a developmental or intellectual disability may not have the ability to consent to sexual activity, as defined by the state laws.
In many instances, the person who has a disability may rely on the perpetrator for care or support, making it even more difficult to come forward.

What is consent?
Consent is an agreement between participants to engage in sexual activity. Consent should be clearly and freely communicated. Consent cannot be given by individuals who are underage, intoxicated or incapacitated by drugs or alcohol, or asleep or unconscious. If someone agrees to an activity under pressure of intimidation or threat, that isn't considered consent because it was not given freely. Unequal power dynamics, such as engaging in sexual activity with an employee or student, also means that consent cannot be freely given.

How does consent work?
When engaging in sexual activity, consent is about communication. And it should happen every time for every type of activity. Consenting to one activity, one time, does not mean someone gives consent for other activities or for the same activity on other occasions. For example, agreeing to kiss someone doesn't give that person permission to remove your clothes. Having sex with someone in the past doesn't give that person permission to have sex with you again in the future. It's important for partners to discuss boundaries and expectations prior to engaging in any sexual behavior.

You can change your mind at any time.
Anyone can withdraw consent at any point if you they uncomfortable. One way to do this is to clearly communicate to your partner that you are no longer comfortable with this activity and wish to stop. Withdrawing consent can sometimes be challenging or difficult to do verbally, so non-verbal cues can also be used to convey this.

Note: Physiological responses like an erection, lubrication, arousal, or orgasm are involuntary, meaning your body might react one way even when not consenting to the activity. Sometimes perpetrators will use the fact that these physiological responses occur to maintain secrecy or minimize a survivor's experience by using phrases such as, "You know you liked it." In no way does a physiological response mean that the person consented to what happened.

Consent does NOT look like this:

- Refusing to acknowledge “no”
- A partner who is disengaged, nonresponsive, or visibly upset
- Assuming that wearing certain clothes, flirting, or kissing is an invitation for anything more
- Someone being under the legal age of consent, as defined by the state
- Someone being incapacitated because of drugs or alcohol Pressuring someone into sexual activity by using fear or intimidation
- Assuming you have permission to engage in a sexual act because you’ve done it in the past

Indicators of Sexual Assault

Because this crime is underreported, knowing the potential indicators of sexual violence can assist you in identifying victimization even when victims are reluctant to disclose. This knowledge can be particularly important if you work with persons with cognitive and communication disabilities who may have limited ability to understand or disclose their victimization.

Unless excessive physical force is used, most victims will not have visible physical injuries from the sexual assault. Coercion, intimidation and the threat of force can all be contributing factors as to why excessive force is not used in many assaults. The absence of physical evidence in no way correlates with the level of fear that victims may have experienced during the assault.

Physical indicators: The most common physical signs of a sexual assault include bruising (on the inner thighs or on the arms where the offender restrained the victim) and trauma to the genital area. Some physical signs are obvious, such as bleeding, and might require medical attention. Other physical indicators, such as pregnancy or a sexually transmitted infection, may be detected days or even weeks after the assault.

Behavioral indicators—examples include:

- **Self-harming behaviors:** Increased drug and alcohol use, self-mutilation, and suicide attempt.
- **Changes in social interactions/ behaviors:** Withdrawal; sexual promiscuity; dressing provocatively; wearing many layers of clothing; running away; aggressive or disruptive behavior; regressive behavior; sexually inappropriate behavior; excessive attachment; and avoidance of certain individuals.
- **Individual behavioral changes:** Sleep disturbances/insomnia; excessive sleeping; change in eating patterns (bulimia, anorexia, weight gain); bed wetting; incontinence; aversion to touch; frequent bathing; avoidance of previously favorite places; compulsive masturbation; isolation; sudden unwillingness to undress or shower in front of a trusted person; and unexplained sexual knowledge inappropriate for developmental age.

Emotional indictors: Emotional trauma caused by sexual violence can manifest itself in numerous ways such as:

- Depression
- spontaneous crying
- feelings of despair and hopelessness
- anxiety and panic attacks
- fearfulness
- compulsive and obsessive behaviors
- feelings of being out of control
- irritable
- angry and resentful
- emotional numbness.

A specific type of emotional trauma, rape crisis syndrome, has been identified as a form of post-traumatic stress disorder specific to sexual violence victims. Each person reacts differently to emotional trauma. It is critical that a service provider not judge a victim based on their response to the violence.

Reporting

Who is required to report adult maltreatment?
"Mandated Reporters" include professionals or professional delegates while engaged in "the care of vulnerable adults." Some of the professions identified as mandated reporters include: law enforcement, education and most health-care related professionals including nursing home administration, nursing, medicine, social work and psychology. A mandated reporter who has reason to believe a vulnerable adult is being or has been maltreated, or has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately (within 24 hours) report.

ANY employee or volunteer of a public or private facility or agency caring for vulnerable adults, including employees not generally involved with patient care (maintenance and food services staff, etc.) must comply with this law.

ANY person concerned about the well-being of a vulnerable adult may report known or suspected maltreatment.

Where do I report maltreatment?
Any incident of known or suspected maltreatment should be reported to MAARC (Minnesota Adult Abuse Reporting Line). MAARC is reachable 24/7/365 at 1(844) 880-1574, or online at: https://tnt09.agileapps.dhs.state.mn.us/networking/sites/880862836/MAARC.

Nothing in the law prevents a reporter from also reporting to a law enforcement agency.
A mandated reporter may meet the reporting requirements by reporting to an internal reporting system; then the facility remains responsible for complying with immediate reporting requirements. A facility may not prohibit a mandated reporter from reporting externally and is prohibited from retaliating against a mandated reporter who reports in good faith.

To the extent possible, all reporters should be prepared to identify the vulnerable adult and the caregiver; the nature and extent of the suspected maltreatment; and any evidence of previous maltreatment; the time, date and location of the incident; and other information regarding the

situation. Identity of the reporter may not be released unless the reporter has given consent or by a court order.

What is the penalty for failing to report suspected maltreatment?
If you are mandated by law to report suspected maltreatment and negligently or intentionally fail to report, you can be held liable for any damages or harm caused by your failure to report the maltreatment. There are also criminal charges for failure to report.

Are there protections for reporting maltreatment?

- Immunity from civil or criminal liabilities for good faith reports
- Identity of reporter is not released without consent of the reporter or by a court order
- There are penalties for retaliation against reporter
- There is civil protection for good faith investigation activities

What happens when a report is filed?
If MAARC determines maltreatment to a vulnerable adult has occurred, the report will be referred to either the county where the abuse occurred, the Minnesota Department of Health or the Minnesota Department of Human Services. Law enforcement may also be contacted if there is reason to believe criminal activity has taken place.

What are the penalties for adult maltreatment?

- Lose the right to work in a facility or agency
- Lose professional license
- Be subject to criminal penalties

What are some of the protective services available to vulnerable adults?

- A restraining order
- A court order for removal of the perpetrator from the residence of the vulnerable adult
- The appointment of a guardian or conservator by a court
- The replacement of a guardian or conservator suspected of maltreatment
- A referral to the prosecuting attorney for possible criminal prosecution of the perpetrator