VANDERHEYDEN, INC.
Policy and Procedure

	Effective Date: 11/13/13 OCFS Approved 8/12/16	**Last revision 2/2017**	**Page 1 of 11**	**Policy Number Volume II A.4.e**
	Board Approval Date: 11/9/2010	**Title: Use of Physical Restraints (Formerly: Physical Interventions)**		

I. BACKGROUND

Vanderheyden strives to create a physical restraint free environment, yet it is realistic that on some occasions, as clinically indicated, physical restraints are a necessary part of the therapeutic milieu. When physical restraints are necessary, the interventions must be reviewed for their appropriateness both on a case-by-case basis and organization-wide.

Employees and volunteers create and maintain a therapeutic milieu by providing a structured and nurturing environment. In addition to the role that staff and volunteers play in providing this structured environment, the agency is committed to the maintenance of a comfortable and safe physical environment with appropriate furnishings and adequate space. Staffing parameters are developed based on the needs of the individual served and are enhanced as necessary. Supervision of those served is of the utmost importance. Each employee and volunteer is obligated to provide the individuals served with support and direction as needed and necessary.

Leadership and administration is required to provide clear policies, procedures and guidelines about crisis management and physical restraints. Each crisis episode is considered a learning opportunity. Each Post Crisis Response, whether for the individual served or staff, is used for personal growth.

All incidents of physical restraints must be documented according to the Incident Definitions Policy.

Additionally, all restraints are tracked on a daily basis by Quality Assurance using the Automated Restraint Tracking System (ARTS), for OCFS Programs plus restrictive involvement applies for OPWDD Programs. This tracking will include the name and age of the individual.

Behavior likely to result in physical injury is best minimized by the maintenance of a therapeutic milieu, which provides consistency, predictability, nurturance, and reinforcement of positive behavior.

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The approved methods for dealing with acute physical behavior are techniques described in "Strategies for Crisis Intervention and Prevention Revised" (SCIP-R) in programs licensed by OPWDD and "Therapeutic Crisis Intervention" (TCI) in programs licensed by OCFS and SED.

Vanderheyden prohibits:

- seclusion or isolation
- chemical restraint
- excessive or inappropriate use of behavioral interventions
- the application of behavior management interventions by an individual served or any other person other than trained, qualified staff
- aversives
- interventions that involve withholding nutrition or hydration or which inflict physical or psychological pain
- forced physical exercise to eliminate behaviors
- forced and/or punitive work assignments
- group punishment or discipline for individual behaviors
- use of physical restraint in response to property damage that does not involve imminent danger to self or others.

II. DEFINITIONS

Acute Physical Behavior - means behavior imminently likely to result in physical injury.

Physical Restraint - means the use of staff members to hold an individual in order to contain acute physical behavior.

Seclusion/isolation - means the practice of separating a person from others in a monitored non-locked room in order to calm the person removed. A person in seclusion/isolation is physically prevented from leaving the room.

Time Away - means the use of an area for an individual to safely de-escalate, regain control, and prepare to meet expectations to return to program. The arca is not locked and is supervised at all times.

III. POLICY

Physical restraints will only be used when an individual is dangerous to self or others and only[1] for the purposes that are documented within an individual's comprehensive Treatment Plan, Behavior Support Plans, Individual Services Plan or Behavior intervention Plan. All use of physical restraints will be reviewed both individually and organizationally.

IV. PROCEDURES FOR OCFS LICENSED PROGRAMS

A. All clinical treatment interventions are described in an individual's behavioral support plan, which is developed in an interdisciplinary treatment-planning meeting. Any plan calling for the use of a physical restraint must show that the use of restraint is clinically indicated, received the consent[2] of the individual or designated surrogate per program requirements, and reviewed by the Human Rights Committee, unless on a emergency basis.

B. Comprehensive Treatment Plans are developed by the treatment team for all individuals within the first month of their treatment. The Comprehensive Treatment Plan will include background information and alerts which are pertinent to the individual such as medical, developmental or learning concerns, etc., as well as intervention strategies and de-escalation techniques. Behavior Support Plans are also written.[3]

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[1] The policy states what we expect. It clearly states in our procedures that we expect action and will evaluate the actions appropriateness.

[2] Agency staff are expected to make and assist parents/legal guardians who maintain legal guardianship to have the opportunity to provide informed consent. If a youth is under 18 years of age from parent or guardian who has legal guardianship (This may include the Commissioner of Social Services under whose jurisdiction that child is placed.) In instances where parents refuse to give or maintain consent the Treatment Refusal Protocol should be enacted.

[3] In OCFS certified programs a Behavior Support Plan may be written to serve as a guide for staff to respond to behaviors. The Behavior Support Plan is considered to be part of the Comprehensive Treatment Plan.

C. Intervention strategies will be reviewed by the treatment teams on a monthly basis and revised as needed to reflect changes in behaviors and/or response. Intervention strategies will be assessed for effectiveness, altered as needed and reviewed for understanding and compliance among all team members. Post Crisis Response activities as defined by the agency's Post Crisis Response Protocol, will inform this process. Alterations in interventions strategies will be reflected in the Behavior Support Plan during the next treatment plan review.

D. Each individual will receive a health assessment within 24 hours of admission. Each individual will also receive a physical examination within seven days of admission unless the individual has been examined within the past ninety (90) days prior to admission of which a copy must be part of the medical record. This physical health assessment will indicate if an individual cannot be held in a physical restraint due to medical reasons. In these instances the Behavioral Support Plan (BSP) will specifically address what staff are to do and what not to do if *an individual is dangerous to self or others.* This may include the use of protective interventionS, contacting an ambulance, police, etc.

E. Employees involved in physical restraints must be trained in TCI. Initial TCI training with the physical component is 28 hours. Employees are required to complete this training prior to their three-month provisional appraisal. Employees not yet trained in TCI cannot be scheduled without trained employees present. Each employee who has completed the initial training must also complete six-eight (6-8) hours of refresher training every six (6) months. Staff must complete both a written and observation test to demonstrate competency.

Employees who must complete the training and certification are:

- Program Directors
- Program Coordinators/Managers
- Nurses
- Case Coordinators

- Clinical Staff
- Guidance Staff
- Direct Care Staff
- Teachers, Teacher Aides, Assistants and Behavioral Aides

Non-direct service personnel who have regular and significant contact with individuals must complete TCI training must complete TCI training in de-escalation techniques, with six-eight (6-8) hour refreshers every six (6) months.

Staff who have successfully completed the TCI initial training and maintained refreshers thereafter may only undertake physical interventions except in situation of imminent danger.

F. TCI must be taught by certified instructors. Instructors must complete the five-day Train – the Trainers program offered through Cornell University's Family Life Development Center and receive notice of certification by the Residential Child Care Project. The training ratio is 10 students to 1 instructor.

G. The comprehensive crisis management course covers:

- Crisis definition and theory
- The use of de-escalation techniques including non-verbal and non-physical techniques such as silence, appropriate facial expressions, eye contact, body language, active listening, prompting, caring gestures, hurdle help, redirection and distraction, proximity, time away, as well as verbal techniques including the tone of voice used, minimal encouragements, "door openers", open and closed questions, limitation of "why" questions and active listening.
- Crisis communication
- Anger management
- Physical intervention techniques
- The legal and policy aspects of the use of physical restrain
- Decision making related to physical interventions
- Debriefing strategies
- Signs of distress and the effect on the child/young person
- Needs and behaviors of the population being served

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The TCI curriculum is approved through OCFS and Cornell University and was created through the Residential Childcare Project. Any departure from the techniques and skills included in the curriculum must be approved by the OCFS Regional Office. The curriculum also includes training in

- Staff self awareness or an understanding or how one's values, beliefs, perceptions and thought influence one's interaction with young people;
- Awareness of the young person including his or her history, patterns of behavior, and characteristic way of responding to stress, limits and authority;
- The effect of trauma on a young person's behavior
- The effect of the environment that surround s the young person including the activity level, the physical environment , and group influences
- Techniques including managing the environment (respecting the young person's personal space, removing additional stimulants, removing potential weapons, tapping out), prompting, caring gestures, hurdle help, redirection, proximity, directive statements and time away;
- Co-regulation and emotional first aid;
- Post crisis response; and
- Specific physical interventions permissible at Vanderheyden are small child restraint, standing restraint, team prone restraint, breaking up a fight, release from a bite, deflecting a swing, and release techniques including 1,2,1 arm and 2 hands, choke, and from a hair pull.

H. Records of the training provided will be kept in Learning and Development in Human Resources. House Managers are to ensure that staff being scheduled are in compliance with the training requirement of this policy. Once staff have successfully completed their initial certification or refresher, training records will be updated electronically.

I. The agency recognizes that staff have the skills and training necessary to make appropriate decisions to handle a crisis. Staff

are encouraged to make decisions that lead to the resolution of a crisis. Employees are expected to use their dynamic professional risk assessment and appropriate judgement.

J. Staff will be trained to stop and think about what the most appropriate response would be, given the factors involved. Staff will be trained to ask themselves four questions:

- What am I feeling now?
- What does the young person feel, need or want?
- How is the environment affecting the child?
- How do I best respond?

K. The only physical restraint allowed in TCI are a standing restraint[4], team prone restraint (including transferring or adding a third person)[5], small child restraint against the wall[6], small child restraint [7]or breaking up a fight[8]. Physical interventions must only be employed for the minimum time necessary or they must cease when the young person is judged to be safe and no longer at risk of self-harm or injury. Tow or more staff members should be involved in any physical intervention to help maintain safety and accountability.

L. A young person may not be permitted to restrain or assist in the restraint of another young person.

M. Restraint may only be used if the youth/child is a danger to themselves , or others, regardless of any other issues or adjudication. The use of a physical restraint involves an inherent

[4] Standing restraint uses a yoke, pivot and hold position where staff slide their arms under a child's armpits and gently bring the child's arms against their chest. If the child is till violent, then staff pivot and hold the child until they cease being violent. Please see page A112 of the TCI Activity Guide Edition 6 for a complete description of the physical intervention.
[5] Team prone restraint uses obtain a hold, yoke, take down, transfer the arm, roll over, and securing the arms and legs technique to maintain the child's safety until they cease being violent. Please see page A129 of the TCI Activity Guide Edition 6 for a complete description of the physical intervention.
[6] Small child restraint against the wall uses obtains a hold, secure the arms and take down techniques. Please see page A124 of the TCI Activity Guide Edition 6 for a complete description of the physical intervention.
[7] Small child restraint uses obtains a hold, secure the arms, and take down and securing the legs techniques. Please see page A123 & A124 of the Activity Guide edition for a complete description for the physical intervention.
[8] Breaking up a fight is when two children fight staff may intervene and separate them by approaching each young person from behind, grasping a hold the waist or hip and turning them around. Workers then assume the protective stance. Please see page A85 of the TCI Activity Guide Edition 6 for a complete description of the physical intervention.

risk of injury to the youth and staff and is safe only when its use is less dangerous than the acute physical behaviors it is designed to control. Staff must weigh this risk against the risks in failing to use a physical restraint when such physical restraint may not be warranted.

N. Staff must not use restraint when they cannot control the young person safely through physical restraint techniques due to such factors as size differently or when the physical environment is unsafe such as when the child is near stairs or near a window. Staff must also not initiate a restraint when he or she is unable to remain calm and in control of their won actions. Further, restraint should not be used when the young person is physically threatening and appears capable of carrying out the threat (use of a weapon, large size, for example), or when the young person's medical condition or medications (as indicated by a physician or RN) increase the risk created by the physical restraint. However, staff are still obligated to pursue other means of handling the young person's behavior.

O. When a child has a weapon capable of inflicting serious injury, staff should clear the area and not attempt physical interventions, but shall maintain supervision until additional assistance (other staff, clinician, police, ambulance, etc) arrives.[9]

P. If a physical restraint needs to be used but is not indicated in the Behavioral Support Plan, the clinician or clinical on-call must be notified immediately. This notification may take place before or after the restraint as resources and time limitation dictate.

Q. As a best practice, Vanderheyden has determined the use of a physical restraint is limited to a maximum of 20 minutes for children aged ten and older without reauthorization from a clinical staff member. In no way does this indicate that restraint should be terminated if there if the child is still unsafe.

[9] During TCI training scenarios are discussed and explored assisting staff in determining the appropriate action in weapon cases.

R. During a physical restraint, staff must assess the individual's need for food, water, and use of bathroom facilities and provide access when safe and appropriate.

S. Physical restraints shall never be used to inflict pain or harm or used for punishment. Physical restraints will be employed only after less intrusive alternative approaches, such as crisis communication, behavior support techniques, emotional first aid, and crisis co-regulation, have been attempted unsuccessfully.

T. If physical restraint is used during business hours, the clinician or clinical psychologist should be notified immediately for assistance in managing and evaluating the situation.

U. If a physical restraint is used after normal business hours, the Administrator On Duty (AOD) or Shift Supervisor should be notified immediately for assistance in managing and evaluating the situation.

V. In addition, if any physical restraint last more than 20 minutes or, two or more physical restraint occur within a short period of time, consultation with a clinician or clinical-on-call is required.

W. Following a physical restraints staff will implement the following protocol:

- Immediate Safety Assessment of both the individual by the AOD/SS/Education Coordinator; face to face assessment of the individual by Health Services staff if available or contact with the nurse- on-call; individual life space interview;
- Completion of all required paperwork (incident/restraint report) immediately but no later than the end of that shift;
- Required information is to include:
  - Name
  - DOB
  - Setting, location
  - Name of staff involved
  - Any staff injured

- Description of incident
- Emergency intervention utilized
- Injuries sustained
- Duration of restraint
- BIP indicated
- BSP indicated

- Notifications:
  - Law enforcement
  - Restraint hotline
  - Nursing, NOC
  - Parent/guardian
  - Placing agency
  - Supervisor/AOD
  - Clinician
- Notification to parent/guardian with invitation for debriefing on incident as designated upon emergency notification form. Incident review with staff members.
- Incident deconstruction by the involved staff's supervisor; and
- Incident Review by the treatment team at the next treatment team meeting.
- Call to restraint Hot Line (ARTS) x 280

X. If it appears that an individual may have sustained an injury immediately prior to or during the use of a physical restraint, an examination by a nurse or physician must be performed as soon as possible. If a nurse or physician is not immediately available the nurse-on-call must be contacted for further instructions. Documentation of the examination should include both a written note and a body chart. Photographs of all injuries will be taken and maintained in the individuals' medical file.

Y. The Quality Assurance Division (QAD) will maintain a log of physical restraints. The QAD administrative assistant will enter all Automated Restraint Tracking System (ARTS) data.

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Z. All physical restraints must be documented on the Restraint Report. This documentation shall include:
- a summary of the incident to explain why the intervention was determined to be necessary
- the de-escalation and less intrusive interventions that were used unsuccessfully
- the individual's reaction to the intervention
- the staff involved
- the actual technique used
- any injuries sustained by individuals or staff, and
- the debriefing that was provided.

AA. Interventions are reviewed by Quality Assurance staff, Incident Review Committee, and Health and Safety Committee, tracked, and trended.

BB. Recommendations for systemic and process changes are forwarded to the appropriate administrator(s) and the President/CEO.

CC. All restraint information will be entered into the Automated Restraint Tracking System (ARTS) as required.

Karen Carpenter Palumbo
President and CEO

2/15/17
Date