Safety and Wellbeing of Children in State Care subcommittee
of the Child Safety and Services Task Force

Indiana Commission on Improving the Status of Children

Decreasing use of restraint and seclusion in facilities that house children in Indiana

A. Overview

A growing body of research[1] points to the urgent need to continue to rethink use of restraint and seclusion in facilities that house children under 18 years old. Restraint and seclusion has been connected to adverse physical and emotional consequences for children. There is also concern that these tools can inadvertently be used disproportionately when responding to youth of color. At the same time, many advancements have been made in identifying and implementing step-down and alternative practices that better serve the safety and well-being of children, safety of staff, and the operational objectives of: juvenile justice centers; psychiatric and other treatment facilities; and, child welfare residential campuses and group homes.

Across Indiana, facilities have made significant changes over the last decade to change policies and culture in order to reduce use of restraint and seclusion. However, there has not been a consistent, statewide approach because of the various types of facilities that house children and the different state and federal agencies that oversee those facilities.

This Resource Guide was created to identify shared principles around these issues, common descriptions of restraint and seclusion, and guidance on adopting policies, forms, and data tracking tools. This guide looks to set a baseline from which facilities that haven't yet tackled this issue or who are not satisfied with the progress they have made can measure their future progress.

The Resource Guide was created by the Safety and Wellbeing of Children in State Care subcommittee of the Indiana Commission on Improving the Status of Children. Members of the subcommittee met several times in 2019 to share ideas for reducing the use of restraint and seclusion and to identify components of the Guide. Members of the subcommittee are (in alphabetical order): Christine Blessinger (IN Department of Corrections), Beryl Cohen (National Association of Social Workers, Indiana Chapter), Kimberly Dailey-Johnson (Damar Services), Chris Daley (Indiana Association of Resources and Child Advocacy), Dr. Jim Dalton (Damar Services); Dr. Kristen Dauss (IN Department of Corrections), Rachael Fisher (Lutherwood/Community Health Network), Kylee Hope (IN Family and Social Services Administration), Angela Howard (IN Department of Child Services), Dr. Shannon Jones (Evansville Psychiatric Children's Center), Heather Kestian (IN Department of Child Services), and Nancy Vinluan (Campagna Academy).

B. Description of Restraint and Seclusion

[1] *Restraint Use in Residential Programs: Why Are Best Practices Ignored?* Janice LeBel, Kevni Ann Huckshon, Beth Caldwell, Child Welfare, Vol 89, No 2, Child Welfare League of America (2010) provides a good overview of research on these issues. Article can be viewed at:
https://pdfs.semanticscholar.org/aaba/2bb7a2360b452e904fab2fb86595f3a83304.pdf

If you're reading this guide, you're likely not surprised that it took the subcommittee awhile to settle on shared descriptions of restraint and seclusion. What was much easier was determining what they weren't. The subcommittee agrees with the definitions of what restraint and seclusion are not as drafted by the *Commission on Seclusion and Restraint in Schools* and found in the Indiana Administrative Code:

513 IAC 1-0.5.1 (b)(3) The use of restraint or seclusion should be seen as an extraordinary event and should never be used as a:

(A) routine strategy implemented to address instructional problems or inappropriate behavior (e.g., disrespect,
noncompliance, insubordination, out of seat);
(B) means of coercion or retaliation; or
(C) convenience.

With this in mind, the subcommittee offers the following descriptions of restraint and seclusion as a basis for a shared understanding in Indiana facilities that house children.

Restraint

The use of physical, mechanical, or other means to temporarily limit free movement of an individual. It is used when there is a serious and imminent risk of harm to self or others, and it is determined – after all other less restrictive measures have been exhausted - as the only means to prevent harm to self or others.

Seclusion

Involuntary, temporary confinement of a child alone or with a staff monitor where the child is physically prevented from leaving or there are negative consequences for leaving. It is used when there is a serious and imminent risk of harm to self or others, and it is determined – after all other less restrictive measures have been exhausted - as the only means to prevent harm to self or others.

C. Policies

In Attachment A, the subcommittee has included several restraint and seclusion policies as examples of how an agency may seek to operationalize its intent to use these tools appropriately and only as necessary. By reviewing policies from different agencies that serve different populations of children, it is easy to see that there are a variety of ways to implement successful restraint and seclusion policies that live up to the principles detailed above.

The first set of policies are from Evansville Psychiatric Children's Center, Campagna Academy, and Damar Services, all Indiana agencies serving populations of youth with significant challenges and endless potential. Following those are standards from National Commission on Correctional Health Care, CARF, and the Council on Accreditation, accreditation agencies providing guidance to organizations nationwide. Taken together, these policies and standards demonstrate that a diverse array of environments can keep staff safe, meet security needs, and promote the wellbeing of youth by limiting or eliminating use of restraint and seclusion.

A number of the agencies who shared policies have done away with seclusion altogether and allow "hands on" restraint in only limited circumstances. For an agency that uses both tools broadly, this may seem like an impossible task. Or, impossible for the population that agency works with. However, that has not proven to be the case with the agencies who were part of the subcommittee. Each of them have undergone a transition where widespread or common use of restraint and seclusion was, over time, greatly diminished or eliminated.

Agency culture change takes time, leadership, and commitment. It also takes clear guidance. Any policy framework that has as one of its goals the reduction in the use of restraint and seclusion, should include some guidance in the following areas:

1. Purpose of the policy
2. Definitions
3. Required Training
4. Allowable forms of restraint/seclusion (if any)
5. Prohibited forms of restraint/seclusion
6. Staff who can authorize use of allowable restraint/seclusion
7. Steps before using a restraint/seclusion
8. Time limits on use of restraint or seclusion
9. Well-being checks during and after use of restraint or seclusion
10. Documentation of use of restraint or seclusion
11. Debrief process for use of restraint or seclusion
12. Data collection on use of restraint or seclusion

D. Forms and Data Collection

As noted above, it is important to document the use of restraint or seclusion. In creating a form, it is important to make sure it is reflective of your agency culture. It should also include the information you need to conduct incident debriefs and collect data.

In Attachment B, you'll find examples of forms for reporting incidents and conducting debriefs from Evansville Psychiatric Children's Center and Damar Services.

It is also important to track when, how, and why restraint and seclusion are used. Here is how LaBel, Huckshorn, and Caldwell describe the role of data:

> Successful reduction initiatives use data in a nonpunitive manner to elevate the oversight of each event and to inform practice and policies (Hardenstine, 2001). This strategy uses data in a way that encourages leadership to identify staff and units that are reducing their use so effective prevention practices can be shared.

Data collection can often seem like a coercive tool. However, as described above, it can be used to help shape culture changes efforts if it framed and used correctly. Some agencies use sophisticated tools to track their use so that they can participate in national efforts. However, Attachment C is a simple

spreadsheet that Evansville Psychiatric Children's Center has successfully used to track its incidents. Even something as straightforward as this tool is a good place to start in establishing a baseline in terms of use of restraint and seclusion and marking progress on changing when and how often your agency uses these tools.

Attachment A

Compilation of seclusion and restraint policies and standards

Policy Name	**Behavior Support and Modification Policy/Procedure**
Policy Location	**Service Policy Manual**
Date of Adoption	**12/2/2005**
Date of Revision	**7/25/2012; 5/15; 7/16; 10/18**
References	BSM 1 Philosophy and Organization BSM 2 Behavior Support and Management Practices BSM Restrictive Behavior Management Interventions Licensing: Children Homes, Caring Institutions 465 IAC 2-9-57 Discipline and Guidance Boarding Homes 470 IAC 3-1. 1-41 Discipline

POLICY

In furtherance of our mission of restoring hope and building dreams for children, youth, and families, Campagna Academy, Inc., believes effective and therapeutic behavior support and management practices begin with promoting a culture of respect and healing and provide our youth with the support they need to manage their own behavior. We believe that in order for behavioral support to be positive, therapeutic, and effective, practices must be consistent, based on an understanding of individual needs and development and in promotion of self-discipline and acceptable social behavior, and with a desire for kind and humane treatment. Additionally, we believe that certain practices are considered unacceptable and will not be condoned if they are cruel or unusual, seek to degrade or humiliate, or have the potential to cause additional harm to the youth we serve. This stance lessens the need for restrictive intervention. Because of our strong commitment to this belief, the CEO and senior management periodically review the use of behavioral interventions, stay abreast of best practice methods, determine when additional agency resources are needed, and seek to incorporate findings into daily practice.

Positive behavior is supported by developing relationships with youth; building on strengths of the youth, their families and social networks; reinforcement of positive behavior; role modeling; providing youth and their families with sufficient information to make informed decisions about their treatment; and responding consistently to all incidents of harassment and/or violence. The use of restraints, escorts and other restrictive behavior interventions are only used when necessary to protect the safety of our youth and staff and to maintain a safe and therapeutic environment and only where clinically indicated, i.e. Residential Programs. We achieve this through initial and ongoing competency-based training and evaluation of all staff and foster parents. Additionally, we periodically review our behavior support procedures and maintain a process for reviewing incidences of restrictive interventions. This enables our agency to make ongoing quality and practical adjustments to support the safest possible environment and continuously work to reduce our use of restrictive interventions.

PURPOSE

To establish procedures for supporting and promoting positive and pro-social behavior in a therapeutic manner, to define unacceptable behavior management practices, and to define restrictive behavioral interventions and their use when necessary to protect the health, safety and well-being of youth.

PROCEDURES

1. Positive and pro-social behavior is supported by staff and foster parents with the youths and families we serve by developing positive relationships, building on identified strengths, reinforcing positive behavior through role modeling and utilizing every available opportunity to a therapeutic advantage, and to respond consistently to all incidents of harassment and/or violence.

2. All youth will have a Crisis Plan in place, and have undergone a thorough assessment before a restraint may be used. The Crisis Plan will indicate if restraints may be used given the history of the client and presenting issues.

3. Restrictive Behavioral Interventions are contraindicated where there is a history of severe trauma, or active symptoms of PTSD.

4. Behavioral support and management interventions used with youth will be the most appropriate type and level for each youth and occasion. Least distressing interventions will be implemented first.

   The following are a list of possible interventions and should not be thought of as all-inclusive.

   - Verbal De-escalation
   - Time Away
   - Caring Gesture
   - Planned ignoring
   - Natural Consequences
   - Role modeling
   - Directive statements
   - Redirection
   - Peer support (mentoring)
   - Journal writing
   - Reflective listening
   - Proximity
   - The Phase System

5. **The following are considered unacceptable behavior interventions. Any participation in these practices whether intentionally or accidentally will be reviewed by supervisors and may result in a disciplinary action of staff or re-training.**
   - Degradation
   - Locked seclusion

- Inappropriate physical activity
- Humiliation
- Verbal of Physical Intimidation
- Cursing or Racial slurs
- Group Discipline
- Aversive or painful physical or psychological stimuli
- Deprivation of youth's rights and needs, such as food, family or home visits, visits with a guardian, court-appointed special advocate (CASA), or placing worker.
- Convenient practices to the staff
- Corporal punishment
- Mechanical, medical, or chemical restraints
- Confinement to a locked or a dark room
- Undue confinement to a bed
- Inappropriate assignment of work
- Manual restraints by foster parents
- Untrained in Bridge Building (BB)
- Restraints in response to property damage where it does not involve imminent danger to self or others
- Restraints for staff convenience, to discipline or as a way to achieve compliance

6. **The following staff members have the authority to approve and make decisions regarding the use of a restraint as a means of behavioral intervention, including the length of time a restraint may occur.**
    - Therapists
    - Team Leaders
    - Unit Supervisors
    - Deputy Director
    - Director of Nursing
    - Residential Manager
    - Clinical Director
    - Director of DD/IDD

7. If at any time during an intervention it is determined that an adverse or unexpected reaction occurs for a youth including any signs of medical distress, exhibiting signs of emotional trauma, or on medication that affects the heart or upper respiratory system, or where the youth indicates that he/she is being sexually stimulated, when staff is not in control or calm, where the physical environment seems unsafe, or where a restraint may led to injury of staff or youth because of size and strength differences, the restraint should be terminated immediately.

8. Restraints shall not be conducted in a public place.

9. All restraints will be recorded in an incident report according to the Incident Reporting procedures by the end of the shift/day. The Primary/Initial Staff who wrote the incident report will send the completed incident report and the debriefing if applicable (physical hold) by the end of your shift to the Supervisor for their review and approval as dictated by the level of incident.

10. All behavioral practices and interventions will be reviewed at least annually by a member(s) of senior management to stay abreast of new regulations, mandates, and best practice methods.

This will be communicated to the leadership team, which then will be communicated to staff at the weekly team meetings.

11. All staff who works with youth and foster parents will undergo Bridge Building Training, as well as other relevant training (see the Training section below) at time of hire, and twice a year as required. Staff who have not been trained in Bridge Building may not participate in the restrictive behavioral interventions described below. Doing so, may result in disciplinary action.

12. All staff and foster parents will undergo policy and procedural training of our Behavioral Support and Management practices.

13. Youth in therapeutic foster care shall not be restrained by foster care providers or parents.

14. The youth and all staff involved shall be debriefed within 24 hours, and preferably by the end of the business day/shift, of the restrictive intervention to prevent negative effects of the intervention. This will give the youth opportunity to process through the occurrence in order to minimize any negative impact to the youth and to explore new ways of handling emotions. This is necessary for staff as well to minimize any negative impact on staff performance.

15. Campagna will notify the Placing Agency in writing (by facsimile or e-mail transmission) either prior to or not later than four (4) hours after its occurrence, of any injury or illness requiring emergency room medical attention, hospitalization, or invasive treatment of resident.

RESTRAINTS (MANUAL HOLDS) & STANDING HOLD PROCEDURES

Definition of Restraint (Manual Holds)

Any manual restraint that is a personal restriction immobilizing or reducing the ability of an individual to move his/her arms, legs or head freely. This does not include devices such as prescribed orthopedic devices, surgical dressings, or bandages, protective helmets, or any other method that involves the physical holding of a resident for the purpose of conducting routine physical examinations or tests.

Definition of "Come Along" Restraint/Escort

The temporary touching or holding of the arm, just above the wrist, shoulder, or back in an attempt to reduce stimuli, help the youth regain control and allow the youth to return to baseline behavior.

Definition of "Hook and Hug" Restraint/Escort

The temporary touching or holding of the arms, where the shoulder begins and at the wrist in an attempt to reduce stimuli, help the youth regain control and allow the youth to return to baseline behavior.

Conditions for Use of a "Come Along/Hook and Hug" Escort

- Youth has refused to leave a harmful (to self or others) environment.
- Attempt to verbally de-escalate were unsuccessful and the client remains to be harmful (to self or others).
- To keep a client safe when a peer is threatening verbal or physical abuse to harm the client.

Conditions for Use of a Restraint (Manual Hold)

- A youth is physically aggressive and presents an imminent risk of harm to self and/or others.
- The youth is causing property damage which creates a safety risk to self and /or others.
- Only reasonable force is to be used when utilizing a restraint.
- All restraints are to be done with a minimum of two staff. If less than two staff members are present, call a Code H and wait for assistance.

Steps of "Come Along" and "Hook and Hug" Restraint (Manual Hold)

The above conditions must be met before engaging in a Restraint.

- Follow Bridge Building (BB) techniques.
- Initial or primary staff will be considered the team leader of the restraint and initiate, lead and end the intervention.
- Initial or primary staff will be the only person to communicate with youth, unless task has been delegated.
- Once fatigued, look for staff assistance to relieve position.
- If a staff member is or becomes the target of a youth's negative behavior, the staff member shall look for staff assistance to relieve his/her position.

Length of Restraint (Manual Hold)

- Restraints will be done for the minimum amount of time not to exceed 30 minutes (15 minutes for youth nine and younger)
- The end of the restraint will begin with a gradual relaxation of the hold as the youth's level of arousal has decreased and the milieu is determined to be safe. This may be signaled by a request from the youth to "let me go, get off of me". The team leader of the restraint will ask the youth to "take a deep breath". If the youth complies, the working up process will begin.
- During the working up process, the team leader should use encouraging and calming phrases such as, "that's better, you can do it", "and you are doing good/fine" etc. The essential thing is to be supportive, calm and quiet. When the youth is calm, the recovery phase begins which will include a period or recuperation.
- The processing step will commence right after the period of recuperation, outlined in the Debriefing Procedure.
- Staff must monitor youth minimally every 5 minutes to ensure proper care is given to protect the youth from harmful inappropriate practices or reactions.
- Staff is to remain aware of a youth's need for biological necessities. Special arrangement is to be made when the restraint occurs during a meal (i.e., food brought to youth after intervention).

DEBRIEFING PROCEDURE

1. A debriefing will occur within a safe, confidential setting within 1 hour after the hold unless the client is not calm enough. Staff must attempt to complete the debriefing in a short while (before the end of your shift). If the clients refuses to debrief with staff after 2-3 attempts make sure to note on the debriefing form the clients' refusal.
    i. **The purpose of this debriefing:**
    b. Evaluate the youth's physical and emotional well-being
    c. Identify the need for counseling, medical care or other services
    d. Identify triggers and modify the treatment plan if appropriate
    e. Facilitate the youth's re-entry into the milieu and other routine activities
    f. Provide both the resident and the staff an opportunity to analyze the events surrounding the incident
    g. Must be a face to face discussion
        i. The discussion must provide both the resident and staff the opportunity to discuss the circumstance resulting in the use of the restraint and **strategies to be used by the staff, the resident, or others that could prevent the future use of the restraint**
2. Staff trained in the use of emergency safety interventions must be in close proximity to the resident, continually assessing, and motoring the physical and psychological well-being of the resident and the safe use of the restraint throughout the duration of the restraint.
    a. Staff must complete the 5 minute observation section of the debriefing form
    b. During the monitoring, staff must be in close proximity at all times
    c. And must discreetly communicate adjustments needed
3. **The Primary/Initial Staff** that was involved in the hold is responsible for meeting with the client to complete the debriefing that takes place after the intervention.
4. The **Post Restraint Physical Form** must be completed by an RN within 1 hour of the hold to assess the resident's physical and psychological status.
5. **Supervisors** must ensure the **Primary/Initial Staff** have completed the debriefing form and review it for accuracy and content.
6. If the hold results in an injury to a resident or staff, **supervisory staff** must meet and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.
    a. Documentation must address any staff procedures that will be changed as a result of the injury or what additional staff training will be required.
7. **The Primary Staff and/or other persons** involved in or who witnessed the incident shall also be a part of the debriefing to assess :
    a. The clients current physical and emotional status
    b. Determine if there are any possible injuries
    c. Determine if there were any triggering events
    d. Determine of how the incident was handled
8. The team will also discuss the incidents in unit/cottage weekly meetings.
9. Family /guardian should be notified ASAP following the incident and documented on the debriefing form.

10. Procedures and/or training needs will be reviewed periodically and will be addressed by Management Team.
11. Once a youth as regained self-control from a restraint, the intervention will be reviewed with the youth using the Processing Steps as follows:
    a. Staff and youth should find a place to have a conversation, free from interruptions and distractions
    b. Staff is to initiate a conversation to see how the events took place from the youth's point of view.
    c. After youth has been given the opportunity to explain his/her side, staff should explain how s/he felt the situation unfolded
    d. Staff should help the youth identify key emotions, triggering events and feelings to connect to his/her actions (i.e. I felt upset (emotion) because my mother ignored my phone call (triggering event), therefore I punched my peer (action).)
    e. Staff should then help the youth come up with a positive alternative plan for when s/he feels negative emotions.
    f. Staff should identify any consequences that come along with the behavior leading up to the restraint and help the youth transition back into programming.
12. When a particular behavior has hurt another person or property, the youth may be asked or required to complete some form of restitution to be determined by the Treatment Team. When Campagna Academy's property is damaged, the youth's financial account will be charged for the repair.
13. The debriefing form MUST be completed in the electronic system immediately after the debriefing
    a. All sections of the debriefing form must be completed

Division of Mental Health and Addiction
Evansville Psychiatric Children's Center

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Owner:	*Brandy Fox: Program Director 2*
Policy Area:	*EPCC Hospital Operations-Care, Tx, & Services*
References:	

Behavior Intervention and Special Treatment Procedures

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Purpose

To establish policy and procedures regarding the use of seclusion and restraint that identify areas of leadership and action that will limit use to clinically justified situations and may, when appropriate, seek to reduce seclusion and restraint use through performance improvement; guide staff efforts to prevent the need to restrain or seclude children; and provide a child-focused framework to guide any actual use through individual orders.

***Note**: EPCC does not use seclusion. Reference to seclusion applies only in the unlikely event a form of seclusion is used in an emergency situation.*

Definitions

Bridge Building

System used to recognize increased anxiety in a child, and use of verbal de-escalation to try to help the child regain control without aggression. When verbal de-escalation techniques do not work and the child becomes aggressive, therapeutic Bridge Building non-strength holds are utilized for the safety of the child, peers and staff. *Bridge Building is a therapeutic non-strength based intervention*.

Clinical Staff

Includes staff in medical, Nursing, Psychology/Social Services, Rehab Therapy, including RN's, psychiatrist, nurse practitioner, psychologist, dietitian, social service therapists, rehab therapists, and recovery assistants.

Emergency

An instance in which there is imminent risk of a child harming himself or others, including staff, when non-physical interventions are not viable, and safety issues require an immediate physical response.

Less Restrictive Alternatives to Seclusion or Restraint

See Approaches to Out of Control Behavior section, Approaches to Out of Control Behavior (Bridge Building), in EPCC Therapeutic Intervention Manual. Includes methods such as redirection, time out, time away,

diversion, etc.

Medication/Chemical Restraint

Medications will at all times be under the direct control of a physician and never be used as a form of discipline.

Chemical restraint is a medication used to control aggressive behavior or to restrict the child's freedom of movement and is not a standard treatment for the child's medical or psychiatric condition. The definition of chemical restraint does not include acute psychopharmacological emergency intervention specifically targeted at aggressive behavior in the context of psychiatric illness.

Medications administered on a regular basis, as part of the individualized treatment and for the purpose of treating the symptoms of mental, emotional, or behavior disorders, and for assisting the patient in gaining progressive self-control over his/her impulses, are not considered chemical restraints.

Restraint

Any manual method or mechanical device, material, or equipment attached or adjacent to the child's body that he/she cannot easily remove that restricts the child's freedom of movement or normal access to one's body.

This **does not apply** to restraint use that is only associated with medical, dental, diagnostic or surgical procedures; when a restraint device is used to meet the assessed needs of an individual who requires adaptive support, i.e., postural support, orthopedic appliances, or medical devices, i.e., helmets, tabletop chairs, bed rails; forensic restrictions for security purposes.

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Seclusion

Involuntary confinement of a child alone where the child is physically prevented from leaving, or there are negative consequences for leaving.

Time Out

A procedure used to assist the child to regain emotional control by removing him/her from the immediate environment and directing him/her to a quiet area or unlocked quiet room.

Unacceptable Uses of Behavior Interventions and Special Treatment Procedures

Punitive disciplinary practices, corporal punishment, denial of food, clothing, sleep, warmth, or sustained social isolation. Violation by staff will result in dismissal, and the matter will be referred to the Prosecuting Attorney for action at his discretion.

Punitive psychological discipline, threats, harassment, humiliation, or any type of discipline directed at undermining self-appraisal and feelings of personal worth. Violation by staff will result in severe disciplinary action.

Use of drugs and medications, other than those in the direct control of a physician.

Policy

The therapeutic environment of EPCC's program will minimize circumstances that result in the use of seclusion and restraint by creating positive environments free of violence and coercion. Distressed children are very vulnerable and particularly at risk for traumatization or retraumatization if seclusion and restraint are used. They should be carefully assessed at the time of their initial assessment process. Use will not be based on prior history, nor be used as punishment or convenience for staff or other children. Emphasis will be on preventative strategies so that interventions using verbal de-escalation and/or positive therapeutic alternatives will occur immediately as need is identified to ultimately reduce or eliminate use of seclusion and restraint. When seclusion or restraint is necessary, the priorities will be safety, the shortest length of time, with the fewest possible negative consequences for children and staff.

Staff will always consider how the intervention will affect the child including

- whether the application or initiation respects the child;
- whether the environment is safe and clean;
- whether the child is able to continue his or her care and participate in care processes;
- whether modesty, privacy, restricted visibility to others, and comfortable body temperature are maintained;
- involving the family when appropriate.

The Plan for Emergency Services provides for emergency medical services.

Seclusion or restraint will be utilized only in an emergency when it is necessary to prevent children from harming themselves or others. Non-physical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response. **Chemical restraint will not be used.**

Leaders will consider the impact of a wide array of factors that may precipitate the use of seclusion or restraint, such as staff training; the composition and level of staffing; the clinical program; the mix of clinical populations; the physical environment; and/or lack of organizational culture of respect.

The PSO Committee will approve procedures on seclusion and restraint use. Procedures will be based on professional practice standards and focus on the child, reducing health and safety risks and protecting the child's rights and dignity.

The use of seclusion and restraint will be monitored and reviewed on an ongoing basis. Each incident requiring the use of seclusion or restraint will be reviewed at the time of the incident and during the debriefing. The treatment team/psychiatrist will review and consideration shall be given to altering the treatment plan, changing the dose or type of medication prescribed, use of different behavioral interventions, and obtaining additional consultation. Any frequent or prolonged seclusion or restraint use will result in a special meeting of the treatment team or a conference (see also Patient Reassessment Plan) including the physician or designated LIP and clinical staff. This review will be documented in the progress notes and may include modifying the treatment plan, changing the dose or type of medication, using different behavioral interventions, or obtaining additional consultation.

1. **ORGANIZATION LEADERS COMMIT TO PREVENTING, REDUCING, AND STRIVING TO ELIMINATE THE USE OF SECLUSION AND RESTRAINT THROUGH:**
    A. Human resources planning will provide an adequate number of qualified staff by:
        1. Assessing staffing needs based on a variety of factors including staff qualifications, the physical design of the environment, diagnoses, co-occurring conditions, acuity levels, and the age and

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developmental functioning of the children.

2. Making requests, based on the assessment, to the Governing Body.
3. Assigning staff, based on the assessment, to program areas.

B. Human Resource and department heads will provide guidelines for development of competency measures.

C. JC standards for competencies will be met for all levels (i.e., those who initiate, evaluate).

D. Leadership and Staff Development will assure:

1. A culture exists which emphasizes the role of non-physical interventions as the preferred interventions; prevention of emergencies that have the potential to lead to the use of seclusion and restraint, reducing the use of seclusion and restraint; striving to eliminate the use, facilitating the discontinuation as soon as possible, and preserving the child's dignity and safety.
2. The debriefing will be used, as appropriate, as part of continuing education and staff training.
3. All new staff receive orientation regarding Bridge Building, seclusion and restraint, SOAR, Roadmap to Recovery, and Trauma Informed Care and Cultural Competence.
4. Ongoing inservice training will occur to keep skills updated. Staff are tested annually to be deemed competent for use of Bridge Building techniques and implementation of seclusion and restraint.
5. Staff are continuously observed. Training/supervision occurs during the incident and during debriefing, and additional training is provided as needed.
6. Aggregate data is monitored to identify training needs.
7. All staff will be trained in approved behavioral intervention techniques per job function.
    a. The training includes:
        1. Impact of restraint and seclusion on the child, including rights and dignity.
        2. Clinical assessment strategies identifying potential behavioral risk factors that could result in the use of restraint or seclusion.
        3. Treatment planning to prevent or manage risk factors.
        4. Effective alternatives for different behaviors.
        5. A basic understanding of the underlying causes of threatening behaviors exhibited by children.
        6. Understanding that sometimes a child may exhibit a threatening behavior that is not related to their emotional condition, i.e., threatening behavior that may result from delirium in fevers, hypoglycemia, etc.
        7. Understanding of how staff's own behaviors can affect the behaviors of the children they serve. For example, believing that control and/or compliance in and of itself is important for recovery, that structure and/or rules for behavior are in and of themselves therapeutic, and recognizing that labeling people as "manipulative" is not therapeutic.
        8. The use of de-escalation, mediation and other non-physical intervention techniques, to minimize the need to use seclusion and restraint.

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9. The safe use of restraint including physical holding techniques, take down procedures. This includes avoiding prone position for safety, and having a non-leader or 4th person monitor if a child is turned on his/her stomach for injection or to avoid choking.
10. Recognizing and responding appropriately to signs of physical distress in children who are restrained or in seclusion.
11. How age, developmental needs, genders, ethnicity, and history of sexual and/or physical abuse may affect the way in which a child reacts to physical contact.
12. Behavior criteria for release from seclusion and restraint.
13. Viewpoints of children who have experienced being placed in restraints are included to help staff better understand the aspects of their use (including research).
14. RN will receive training and demonstrate competence in assessing the needs for seclusion and restraint, assessing the need for continuation of seclusion and restraint and the need to secure a new order.
15. Creating a trauma informed, violence and coercive free environment and approach.

8. Staff who conduct the 15-minute assessments are trained.
    a. The training includes:
        1. Taking vital signs and interpreting relevance to the physical safety of the child in restraint or seclusion.
        2. Recognizing the nutritional and hydration needs.
        3. Checking for circulation and range of motion in extremities.
        4. Addressing hygiene and elimination.
        5. Addressing physical and psychological comfort.
        6. Assisting children in meeting behavioral criteria for discontinuing restraint or seclusion.
        7. Recognizing the readiness for discontinuing restraint or seclusion.
        8. Recognizing signs of any incorrect restraint techniques.
        9. Recognizing when to contact a medically trained Licensed Independent Practitioner (LIP) or emergency medical personnel to evaluate and/or treat the child's physical status.
    b. Clinical staff members who are authorized in the absence of a LIP to initiate restraint or seclusion, and the RN who performs evaluations/re-evaluations of children in restraint or seclusion to assess need for seclusion and restraint, readiness for discontinuation or establish the need to secure a new order, receive training and demonstrate competence cited above.
    c. All new employees review the behavior intervention and special treatment procedures policy, seclusion/restraint procedures, and Bridge Building techniques during orientation.
    d. All clinical staff participate and are certified in Bridge Building training (scheduled as soon as possible after employment) with periodic review and annual competency update.
    e. All clinical staff supervisors review at least annually with staff the special treatment procedures policy and seclusion/restraint procedures.

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f. All clinical staff are trained and tested for competency on the milieu program SOAR during the first quarter orientation.

E. The child and parents/legal guardian will be educated regarding the seclusion and restraint policy and their rights and responsibilities.

1. Clinical staff will:

a. Assess and document the educational needs of the child and family/guardian.

1. All parents/guardians of children admitted will sign a Consent for Treatment form including use of seclusion and restraint.

b. Include in the education explanations of behaviors that might cause seclusion and restraint to be incorporated into the treatment plan based on assessed needs of the child or on an emergent basis; a description of how staff use seclusion and restraint; available alternatives to the use of seclusion and restraint; ways the family can participate in the treatment process that might limit or halt the use of seclusion or restraint use; discussion, consideration of and incorporating, when possible, the child's and family's insights and preferences related to prevention and alternatives.

1. Document the education of the child and family in the progress notes.

2. **PERFORMANCE IMPROVEMENT/RISK MANAGEMENT ACTIVITIES**

A. EPCC collects data through an established ongoing measurement and assessment process that focuses on:

1. Reducing the occurrence of emergency situations which precipitate the use of seclusion and restraint.
2. Increasing the safety of the child and staff when seclusion and restraint is used.
3. Understanding the root cause of the emergency situation.
4. Preventing the need for the use of seclusion and restraint.
5. Assuring that emergency medications are being used appropriately (the purpose is not to restrict movement, but to help the child gain control of his/her behavior and decrease anxiety, anger, and aggression).
6. Identifying any need to redesign care processes.

B. Data is collected, classified, and analyzed for both dorms using a patient identifier, and includes shift; who initiated the process; number of episodes for each child; day, time and length of episode; type of restraint used; frequency of use; injuries to staff or child; age and gender of child; use of psychoactive medications as an alternative for, or to enable discontinuation of, restraint or seclusion.

C. Particular attention is paid to the number of episodes per child, multiple instances of use for a child within a 12-hour period, interviews with child and/or family, interviews with staff, and medical records.

D. Physician/Licensed Independent Practitioners (LIP's) participate in measuring and assessing the use of restraint and seclusion for all children at EPCC.

E. Reviews

1. Concurrent review.

a. Physician or designated LIP (and other appropriate administrative or clinical staff) reviews daily reports five days a week and weekend reports on Monday.

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2. Retrospective review.
    a. Treatment teams review monthly data during routine treatment team meetings and document all related decisions actions in the medical record.
        1. Patient care monitoring interdisciplinary sessions may be held at the request of treatment teams to assist in the care of children identified with potentially dangerous behaviors.
    b. PSO reviews monthly reports, including comparative data, which are generated by Health Information Services and processed by QI for review and assessment of frequency, trends, and unusual or unwarranted uses.
        1. PSO Committee notifies the appropriate Case Manager, treatment team, staff or committee of the need for further review or action.
    c. Safety/Risk Management Committee reviews quarterly reports for injuries related to use of seclusion and restraints.
    d. PSO reviews annual reports, including comparative data and analysis.
    e. Any indication for the need for further study or action is communicated by the reviewing group to the appropriate staff member, treatment team, or committee, and Office of State Hospitals and Regional Centers.
3. Incidents exceeding four hours review.
    a. The Medical Director or designee reviews daily all incidents exceeding four hours.
    b. The physician responsible for the child's care notifies PSO if the child has been in seclusion or restraint for more than 12 hours, or for more than 2 episodes in a 12-hour period.
        1. PSO is notified every 24 hours if either of the above conditions continue.
        2. PSO is clinically accountable to review the information, assess the need for additional resources to facilitate the discontinuation of restraint or seclusion, and to minimize recurrent instances of restraint and seclusion.
    c. The Medical Director or designee reports all incidents exceeding 12 hours to the Director, Office of State Hospitals and Regional Centers, and the Quality/Accreditation Manager, Office of State Hospitals and Regional Centers, for review. The report should be e-mailed (without child's name and following e-mail policy guidelines) at the end of each week and include steps taken to reduce use.

F. Data will be incorporated into:
    1. Treatment plans (i.e., what interventions work, change in treatment plan).
    2. Operational plans.
    3. Redesign of patient care processes.
    4. Statewide data collection comparison.
    5. National Research Institute (NRI) Performance Measurement System for national comparison (JC ORYX initiative).

3. **STAFF RESPONSIBILITIES**

A. **Initial Assessment at Admission**

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1. The child and parent/guardian are informed of EPCC's philosophy on use of seclusion and restraint, the seclusion and restraint policy, and their rights and responsibilities.
2. The educational needs of the child and parent/guardian are assessed regarding restraint and seclusion.
3. Parent/guardian will be educated and promptly notified of each use of seclusion or restraint per their notification preference (documented on the Consent to Treatment form). Parent/guardian may change their notification preference at any time.
4. The child and parent/guardian assist in the identification of techniques, methods, and tools (including type of physical intervention) that help the child control his or her behavior. This is documented in the treatment plan and a chill out plan is formulated.
5. Pre-existing medical conditions or any physical disabilities and limitations that would place the child at greater risk during seclusion or restraint are identified.
6. Any history of sexual or physical abuse that would place the child at greater psychological risk during seclusion or restraint is identified.
7. The treatment team assesses and documents in the treatment plan the child's initial and ongoing needs related to seclusion and restraint, as well as the educational needs of the child and family.
8. All use is documented in the medical record and reflects policy; and includes clinical justification for use, written order that meets requirements, measures taken to protect the rights, dignity, and well-being of the child including monitoring, reassessment and attention to needs.

B. **Initial Orders for Seclusion or Restraint Use**

1. Clinical staff who are aware of dangerous or escalating behavior should notify the RN of the situation as soon as possible.
2. Clinical staff who are not LIP's, but authorized by the Superintendent and Medical Director, can assess and initiate restraint use.
3. The RN will assess the situation and need for seclusion or restraint.
4. If the RN feels use of seclusion or restraint is appropriate, he or she will immediately notify the physician or designated LIP.
5. Only the RN or physician or designated LIP, based upon assessment, can initiate seclusion or restraint.
6. Bridge Building holds can be implemented without RN approval if a severe physical altercation between two children or a staff member occurs resulting in imminent danger and a potential of bodily harm. Even when physical aggression occurs, staff should utilize Bridge Building techniques such as proper body space, comfort zone and blocks while attempting to de-escalate the child before any hands on should occur.
7. All seclusion or restraint incidents will be reviewed by QI and PSO.
8. The physician or designated LIP will assess the need for seclusion or restraint.
9. The physician or designated LIP will determine if restraint or seclusion needs to be continued.
10. The RN will obtain an order from the physician or designated LIP.
11. The RN will make sure the order is carried out by trained, authorized staff.

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12. Initial written orders for seclusion and restraint are limited to the following
    a. **Children and adolescents ages 9 to 17 - 2 hours.**
    b. **Children under 9 - 1 hour.**
    c. **Physician or designated LIP will be notified hourly of need to continue seclusion or restraint.**
13. **If seclusion or restraint continues beyond the expiration of the time-limited order, the RN must evaluate the need for continued seclusion or restraint. If needed, a new time-limited order must be obtained from the physician** or designated LIP**.**
14. Each order is signed, dated and timed by the physician or designated LIP, and includes the criteria under which the child can be released prior to the time specified on the order.
15. If the ordering physician or designated LIP is not the treating physician, the treating physician must be consulted as soon as possible, no later than the next working day.
16. A physician or designated LIP must see the child and evaluate the need for seclusion and restraint within one hour after initiation of use.
    a. The child does not have to stay in seclusion or restraint until the physician or designated LIP arrives for the assessment. The child can be processed out if he is calm, using step downs such as open door, chair in back of LA, and then return to LA.
17. On evenings, weekend and holidays when a physician on call or designated LIP is being utilized, the AOC will be notified to review the need for use of seclusion and/or restraint.
    a. Any injury (staff or patient) will result in the AOC coming to the facility for the debriefing.
18. If seclusion or restraint continues beyond the expiration of the time-limited order, the RN must evaluate the need for continued seclusion or restraint. If needed, a new time-limited order must be obtained from the physician or designated LIP.

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C. **Assessment, Reassessment, Documentation and Reporting**

As a preventive measure, clinical staff will monitor the child for activity/behavior changes such as increased agitation and make an attempt to help the child regain self-control by the safest, most effective and least restrictive means.

Note: EPCC does not use mechanical restraints.
All children in **restraints** in a seclusion room/bedroom must be monitored by "eyesight," "line of vision," or one-to-one observation on a continuous basis. Audio and video equipment may only be used in addition to the above.

All children in seclusion must be monitored by "eyesight," "line of vision," or one-to-one observation on a continuous basis. If a child is in a physical hold, an additional staff person must be present to observe.

Documentation is on approved forms, which allow for the collection and analysis of data in performance improvement activities.

1. The physician or designated LIP does the following.
    a. Assures that assessed needs of the child are met.

b. Completes and documents a face-to-face evaluation within one hour after initiation of use.

c. Reviews with staff the physical and psychological status of the child, and determines whether seclusion or restraint should be continued.

d. Works with the child and staff to identify ways to help the child regain control and discontinue seclusion and restraint, makes necessary revisions to the treatment plan, and if necessary, provides a new written order following time limits noted in C.2.i.

e. Never writes the order as a standing order or on an as needed basis.

2. The RN does the following.

a. Explains the reason for seclusion or restraint to the child.

b. Determines the child's response to seclusion or restraint throughout the duration of the seclusion or restraint and determines actions to be taken.

c. Is responsible for maintaining the safety and well-being of the child and incorporating specific needs into the plan of care.

d. Uses clinical judgment and the child's needs to determine the frequency of assessments by the RN, but not less than every 15 minutes.

e. Face to face assessment at least every 15 minutes and documents:

1. Signs of any injury associated with the application of seclusion or restraint (marks, injuries, swelling, discoloration).

2. Nutrition/hydration.

3. Circulation and range of motion in extremities.

4. Vital signs.

5. Medical problems (i.e., need to increase frequency of observation for child with breathing problems).

6. Hygiene and elimination.

7. Physical and psychological status and comfort (behavior changes/increased agitation, feelings of isolation, confusion, anger, depression).

8. Release from seclusion or restraint, unintentional limitation of rights and dignity.

9. Child's clinical condition and readiness for discontinuance; release should be as soon as possible based on release criteria.

10. Documents within the shift on the Behavioral Intervention Sheet (BIS).

3. RN or RA does the following:

a. Conducts continuous monitoring by "eyesight", line of vision, or one-to-one observation.

b. Determines the environment is clean, safe, well lighted and temperature is comfortable; assesses if additional help is needed; removes shoes, belts, etc.; assures child can be seen through seclusion window and door lock is functioning; assures mat is available.

4. **Seclusion documentation**:

a. The RN documents:

1. On Behavioral Intervention sheet: hydration, toileting needs attended to a minimum of

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every hour, meals offered at meal/snack times, marks/injuries, checks at minimum of every 15 minutes.

2. On Behavioral Intervention sheet—general observations a minimum of every hour including, behavior escalation/de-escalation, alertness, breathing/circulation, not in distress (quiet/calm more than five minutes), possible removal, need for PRN.
3. That the physician or designated LIP was notified, order written, and RN signed off on order.
4. Shift report to RN—name, type restraint or in seclusion, time in/out, reason, etc.

b. Clinical staff documents and completes all appropriate forms within shift.

1. **Behavioral Intervention Sheet** (BIS)—
    a. results of initial clinical assessment
    b. clinical justification for use including rationale for type of physical intervention selected
    c. consideration or failure of nonphysical intervention
    d. measures taken to protect the rights, dignity and well-being of the child including monitoring, reassessment and attention to needs
    e. child informed of criteria to end seclusion or restraint
    f. adverse results of initial clinical assessment, justification for use, and inadequacy or ineffectiveness of less restrictive interventions
    g. actions taken
    h. type of restraint placed in or seclusion
    i. time placed in/out
    j. reason for seclusion or restraint
    k. continuous monitoring, child's response
    l. notification of physician or designated LIP
2. **Progress Notes**—brief notation for cross-reference
    a. notification of family when appropriate
3. Incident/Injury Report—if injury occurs during seclusion.
4. Any review or process forms in effect.
5. **Shift Report** to RA
    a. time of order, child's name, type restraint or in seclusion, time in/out, reason, etc.

c. Nursing department staff documents:

1. All incidents on daily Seclusion and Restraint Log for performance improvement.

d. The physician or designated LIP documents:

1. A written order on the Behavioral Intervention form that meets the requirements.
2. Signs, dates, and times each order in the medical record and includes the condition under which the child can be released.

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3. Assesses any changes in the child's mental or physical status and documents in the medical record.
4. The condition of the patient after direct evaluation including respiratory status and any physical injury from seclusion or restraint.
5. If the physician or designated LIP is not the patient's assigned treatment team physician, he/she will provide documentation and notification to the treatment team physician at the earliest time. This notification can be direct consultation, through a written report, and/or verbal report in daily reports. The treatment team physician will make appropriate documentation in the medical record that the notification was received.

5. **Restraint documentation**:
   a. The RN documents:
      1. Circulation/condition of limbs checked a minimum of every 15 minutes.
      2. On Behavioral Intervention sheet: hydration, toileting needs attended to a minimum of every hour, release and position change completed a minimum of every hour, meals offered at meal/snack times, marks/injuries check a minimum of every 15 minutes.
      3. On Behavioral Intervention sheet—general observations a minimum of every hour including, behavior escalation/de-escalation, alertness, breathing/circulation, not in distress (quiet/calm more than five minutes), possible removal, need for PRN.
      4. Physician or designated LIP notified, order written, and RN signed off on order.
      5. Shift report to RN—name, type restraint or in seclusion, time in/out, reason, etc.
   b. Clinical staff documents and completes all appropriate forms within shift.
      1. **Behavioral Intervention Sheet** (BIS)
         a. results of initial clinical assessment
         b. clinical justification for use including rationale for type of physical intervention selected
         c. consideration or failure of nonphysical intervention
         d. measures taken to protect the rights, dignity and well-being of the child including monitoring, reassessment and attention to needs
         e. child informed of criteria to end seclusion or restraint
         f. adverse results of initial clinical assessment, justification for use, and inadequacy or ineffectiveness of less restrictive interventions
         g. actions taken
         h. type of restraint placed in or seclusion (if prone position is necessary, documentation needs to reflect monitoring of face and lip color and respiration).
         i. time placed in/out
         j. reason for seclusion or restraint
         k. continuous monitoring, child's response
         l. notification of physician or designated LIP

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2. **Progress Notes**—brief notation for cross-reference
    a. notification of family when appropriate
3. Incident/Injury Report–if injury occurs during a physical hold.
4. Any review or process forms in effect.
5. **Shift Report** to RA
    a. time of order, child's name, type restraint or in seclusion, time in/out, reason, etc.

c. Nursing department staff documents:
    1. All incidents on daily Seclusion and Restraint Log for performance improvement.

d. The physician or designated LIP documents:
    1. A written order on the Behavioral Intervention form that meets the requirements.
    2. Signs, dates, and times each order in the medical record and includes the condition under which the child can be released.
    3. Assesses any changes in the child's mental or physical status and documents in the medical record.
    4. The condition of the patient after direct evaluation including respiratory status and any physical injury from seclusion or restraint.
    5. If the physician or designated LIP is not the patient's assigned treatment team physician, he/she will provide documentation and notification to the treatment team physician at the earliest time. This notification can be direct consultation, through a written report, and/or verbal report in daily reports. The treatment team physician will make appropriate documentation in the medical record that the notification was received.

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D. **Discontinuation of Seclusion or Restraint**

The physician or designated LIP or RN assesses the need to continue seclusion or restraint. Release will occur when the child has met the criteria for release. No seclusion or restraint episode should continue if the child is asleep. The need for continued seclusion or restraint is documented by the RN and the nursing staff. If there is no assessed need for continuation, the seclusion or restraint will be discontinued. Documentation also includes the debriefing and notation of any injuries that occurred.

The RN documents, upon release, on the Behavioral Intervention sheet the justification for removal, date/time of removal, and status of the child following release.

The nursing staff documents on the Behavioral Intervention sheet and communicates through shift report that seclusion or restraint was discontinued.

E. **Debriefings**

The child, and if appropriate the family, and staff participate in and document a debriefing as soon as possible and appropriate, but no longer than 24 hours, after the child is released from seclusion or restraint. Documentation in the medical record should include that a debriefing was completed. The debriefing is communicated to the child's treatment team.

1. **Child debriefing** is part of the Behavioral Intervention Record.
    a. The debriefing of the child should be completed by someone not involved with the intervention.
    b. Information from child should include:
        1. What he/she thinks caused him/her to become so upset.
        2. What could be done next time he/she is upset to prevent seclusion and/or restraint.
        3. How staff could help.
        4. Any concerns about the intervention.
        5. If he/she felt pain, and if so, where.
2. Immediate staff debriefings identify process improvement opportunities of individuals, teams, and the overall system.
    a. The interviewer should be a professional staff person, preferably not involved with the incident.
    b. Information should include:
        1. Behaviors observed that led to a Seclusion or Restraint (use Bridge Building criteria).
        2. What triggered the incident.
        3. Alternatives that were used.
        4. Staff's feelings during the incident.
        5. Staff's perception of patient's response when placed in and when released.
        6. Could incident have been handled better and was seclusion or restraint necessary.
        7. Was the patient treated with dignity and respect.
3. Formal debriefings are held for each incident of seclusion and restraint, Monday, Wednesday, Friday with PSO staff and RNs.
4. Follow-up debriefings are held for random cases and those having more than one intervention in a week and includes direct care staff involved and when possible, the child. A PCM is completed at that time.
5. When indicated, modify the child's treatment plan.
6. Collect data for performance improvement activities.
7. Debriefing forms are reviewed by the MD, Clinical Director, and Nursing Director for content and needed follow-up.

F. **Reporting of Deaths**

Any death that occurs while a child is in seclusion or restraints, or where it is reasonable to assume that a child's death is the result of seclusion or restraint, is to be treated as a sentinel event and handled per EPCC policy A6 Sentinel Event. The DMHA Office of State Hospitals and Regional Centers will be responsible for making a report to CMS.

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References

CMS 42CFR 482.13
TJC CTS.05.06.01-35

Attachments:

No Attachments

Approval Signatures

Approver	Date
Brandy Fox: Program Director 2	09/2017
Lottie Cook: Broad Band Executive	09/2017
Brandy Fox: Program Director 2	09/2017

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	2.CS.122 **Residential Restrictive Interventions – Use of Physical Restraint**		
	Department	Residential Programs & Services	
	Effective Date	10/27/2011	**Last Revised** 9/1/2014, 11/20/14, 1/29/16, 12/5/16, 9/1/17
	Scope	All clients, and employees and agents of Damar Services, Inc. ("Damar" or the "Agency").	
	References	5.HR.402 Standards of Conduct	

DEFINITIONS

Acute Physical Behavior	Behavior likely to result in physical injury to the aggressive client, other clients, staff members, or other persons in the area. Clients, staff members, and others are at imminent risk of physical harm.
Crisis Responders	TCI trained staff members will be designated to respond to crises throughout each program. All TCI trained staff may respond to crisis codes, but a specific individual is identified during each shift to act as the primary responder for all codes.
Individual Crisis Management Plan (ICMP)	The ICMP is both a planning document and a working document which provides a history of each client's crisis behavior and a plan that will reduce or eliminate the need for physical intervention. At a minimum, the ICMP should include a basic screening for any pre-existing medical conditions that would be exacerbated if the young person were involved in a physical restraint or emergency safety intervention, a synopsis regarding the child's crisis behavior, a screening to determine if there is a history of physical or sexual abuse, a plan for specific behavioral interventions, a plan for specific physical interventions, and a review process that allows for update of the ICMP.
Staff Debriefing	Resource or member of management will conduct a debriefing session that includes, at a minimum, a review of and discussion of the emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention; alternative techniques that might have prevented the need for physical intervention; the procedures, if any, that staff are to implement to prevent any recurrence of the use of physical intervention; the outcome of the intervention, including any injuries that may have resulted from the use of physical intervention. Staff will document in the client's medical record that both debriefing sessions took place and include in that documentation the names of staff that were present for the debriefing, and any changes to the client's ICMP that result from the debriefings. This staff debriefing should include: (1) precipitating factors or triggering events; (2)

	behavioral management strategies attempted; (3) other TCI approved techniques that were not considered or attempted; (4) recommendations for change in future crisis de-escalation or interventions; and (5) a brief list of coping skills or alternative behaviors identified by the client, at least one of which will be practiced by the client during the life space interview and prior to returning to programming on the unit.
Life Space Interview (LSI)	An LSI is a TCI training behavioral intervention designed to help young people understand how thoughts and feelings result in behaviors and how those behaviors affect themselves and others. A long term goal of the LSI is to help teach better and more effective ways of dealing with stressful situations. The LSI should be completed with the client after each physical intervention. It should be noted that while a youth may initially refuse completion of the LSI, it is imperative that the LSI be completed at some point. A part of the therapeutic process is working with the youth to walk through the LSI and process the event. This allows for therapeutic closure of the event.
Physical Restraint	The use of staff members to hold or otherwise restrict the movement of a young person in order to manage acute physical behavior. Restraints may be in the form of standing holds, seated holds, or supine (face up) restraints. **The use of mechanical restraints or PRONE (face down) restraint is not permitted at any Damar Services Program.** The least restrictive method of restraint shall be used to contain the acute physical behavior. All physical interventions are to be conducted according to TCI protocol. All staff participating in physical intervention shall be TCI trained.
Serious Injury	Any significant impairment of the physical condition of the client as determined by qualified medical personnel. This includes, but is not limited to, carpet burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.
Emergency Safety Situation	The unanticipated client behavior that places that client or others at serious threat of violence or injury if no intervention occurs and the situation then requires an Emergency Safety Intervention or restraint.
Emergency Safety Intervention	The use of restraint as an immediate response to an Emergency Safety Situation described above.

PURPOSE

The purpose of Therapeutic Crisis Intervention training is fivefold, helping Damar Services staff members to

provide the following:

A. A model of intervention for supporting physically aggressive behavior of Damar Services clients;

B. Guidelines for developing and maintaining a team approach to crisis situations that enhance client and staff safety;

C. Focus on proactive de-escalation as the initial means of intervention;

D. Guidelines for implementation of physical restraints and emergency safety interventions for acute client behavior; and

E. An organized, ongoing crisis education and training program for all direct care employees.

POLICY

It is the goal of Damar Services to create a physical, social, and organizational culture which limits the use of physical restraints and emergency safety interventions to emergency safety situations where the client, other clients, staff members, or others are at imminent risk of physical harm.

To achieve this goal, Damar Services uses the Therapeutic Crisis Intervention System (TCI) developed by Cornell University under a grant from the National Center on Child Abuse and Neglect in the early 1980s. TCI is a crisis prevention and intervention model for residential childcare facilities. TCI guides staff members in preventing crises from occurring, de-escalating potential crises, managing acute physical behavior, and reducing potential and actual injury to clients and staff. TCI physical interventions are not used as a consequence for client behavior, as a punishment for client behavior, as a consequence for non-compliance with unit programs, or as a consequence for destruction of Damar Services' property.

The following guidelines will govern emergency safety interventions with clients who, as a consequence of mental illness, behavioral disorder or situational stressors, create emergency safety situations and become physically aggressive toward staff members, other clients or themselves, or when clients pose imminent harm to self or others.

The use of PRONE restraint or mechanical restraint is not permitted at any Damar Services Program.

All interventions shall:

A. Protect and preserve the client's health, safety, rights, dignity and well-being. Be based on the client's Individual Crisis Management Plan (ICMP) which is developed upon admission and refined throughout the client's treatment.

B. Be done in a safe manner with monitoring and reassessment. On staff nurses are required to respond to and monitor all physical restraints. If a nurse is not available, a supervisor or other TCI trained staff person will observe and monitor the restraint.

C. Follow ICMP recommendations and TCI guidelines with emergency safety interventions or physical restraint being used as a last resort for a client who creates an emergency safety situation and represents a danger to themselves or others.

TRAINING

All Damar Services direct care staff will receive a minimum of 4 days (28 hours) of TCI training during new employee orientation. Training covers:

A. Crisis definition and theory;

B. The use of de-escalation techniques;

C. Crisis communication;

D. Anger management;

E. Physical intervention techniques;

F. The legal, ethical, and policy aspects of physical interventions;

G. Decision-making related to physical interventions;

H. Debriefing strategies; and

I. Signs of physical distress and effect on the young person.

Staff members must also have demonstrated competency in performing the physical intervention techniques, which is measured and documented according to Cornell University's TCI guidelines. Staff members must score 80% or higher grade in order to pass the written portion of TCI training. Staff members must also pass the physical skills portion of TCI training before being assigned to a unit. Staff members who do not pass either the written test or the physical skills test may be given the opportunity to retrain and retake the tests. Continued employment status may be contingent on the outcome of TCI testing.

All TCI trained employees will attend initial and refresher TCI trainings in accordance with both regulations and TCI guidelines.

All TCI training will be conducted by Cornell University TCI certified trainers. Other restraint trainings and techniques will not be used by Damar Services employees.

RESPONSIBILITY OF STAFF MEMBERS DURING CRISIS SITUATIONS

A. To be skilled in TCI behavior management techniques, TCI physical skills and life space interviewing.

B. To proactively recognize signs of a potential emergency safety situation and intervene appropriately, both in terms of deescalating the young person or recognizing the need to call for a code.

C. Assess the situation of each crisis team call. Identify resources needed to ensure unit safety.

D. To remove items at the beginning of a shift, such as jewelry, that may inadvertently cause injury during a TCI physical intervention.

E. To manage the physical environment in an effort to remove any potential weapons from the area, such as chairs, pencils, etc.

F. To be present during the completion of the life space interview following the crisis.

G. To be present during the supervisor debriefing of the crisis intervention. To follow only TCI approved protocols.

H. Communicate with the client in crisis during the "letting go" or release process.

I. To help support and deescalate the clients on the unit where the restraint or emergency safety intervention occurred.

J. To document antecedents to the restraint, and all attempts at less restrictive interventions, as well as why those less restrictive interventions were not successful. This should include:

    1. Precipitating factors or triggering events;

    2. Behavioral management strategies attempted;

    3. Other TCI approved techniques that were not considered or attempted; and

4. Recommendations for change in future crisis de-escalation or interventions.

This will be documented on the emergency safety intervention form by the end of the shift and placed in the medical record.

RESPONSIBILITIES OF NURSING

A. Respond immediately to any crisis.

B. Nursing staff will observe the restraint, checking the client's breathing, skin color, ROM, and directing the restraint and techniques used by staff. This will be documented in the restraint flow record at a minimum of every 15 minutes.

C. Assimilate information provided by direct care staff involved in the restraint process in providing release criteria to the client and determining when to release the client.

D. Nursing staff will provide instructions for the client and staff upon release of the restraint, including identifying an area for the client to sit, offering water or bathroom.

E. Provide psychological and physical assessment to a client within 24 hours of the termination of the restraint event.

F. If any injury occurs to client as a result of the restraint, nursing will assess, treat, and document the nature of the injury. In the case of serious injury, nursing will contact the Director of Nursing in order to determine if further instructions in how to care for that particular client. If necessary, further medical care may be arranged with an outside entity (typically St. Francis or Riley).

G. Contact the family or legal guardian of the client and notify them of the restraint/emergency safety intervention, including any physical complaints or injuries.

RESPONSIBILITIES OF MANAGEMENT OR RESOURCE TEAM MEMBER

A. Contact Clinician on Call to inform them of a potential emergency safety situation or obtain authorization for restraint. Staff will make every effort to obtain this order prior to the initiation of an emergency safety intervention or restraint.

B. Ensure that a Life Space Interview (LSI) is conducted with each client in crisis by one or more staff members who responded to the crisis. Ideally, the staff person directly involved in the incident resulting in the need for the LSI is the staff who is completing the LSI and should be completed as quickly as possible. Keep in mind that the client may need a moment to calm down in order to benefit from completing the LSI. This LSI will include:

1. The client's thoughts about what led to the restraint,
2. Their feelings before, during, and after the restraint,
3. The connection between their thoughts, feelings, and actions,
4. A brief list of coping skills or alternative behaviors identified by the client, and
5. An opportunity for the client to practice at least one of the alternative coping skills prior to returning to programming on the unit.

C. Make crisis response assignments during the day and evening shifts.

D. Conduct a debriefing session, or ensure debriefing has occurred, with all staff involved in the incident to include, at a minimum, a review and discussion of the emergency safety situation that required the intervention and what interventions may be successful in the future. Ensure that staff will document in the client's medical record that both LSI and debriefing sessions took place and include in that documentation

the names of staff who were present for the debriefing, and any changes to the client's ICMP that result from the debriefings. This staff debriefing should include:

1. Precipitating factors or triggering events;
2. Behavioral management strategies attempted;
3. Other TCI approved techniques that were not considered or attempted; and
4. Recommendations for change in future crisis de-escalation or interventions.

E. Ensure the presence of an on shift unit nurse during any TCI physical interventions.

F. Ensure notification of parent or legal guardian, to include any physical complaints or injuries, within 2 hours of the physical intervention.

RESPONSIBILITIES OF ADMINISTRATIVE STAFF

A. Review incident report of the restraint the next business day during flash meeting.
B. Review ESI packet the next business day during flash meeting.
C. Use of ESI is submitted to PQI for ongoing analysis.

ROCEDURE FOR USE OF PHYSICAL RESTRAINTS AND EMERGENCY SAFETY INTERVENTIONS

A. The facility will inform both the incoming client and the client's parent(s) or legal guardians of the facility's policy regarding the use of restraint during an emergency safety situation that may occur while the client is in the program. The facility will provide a copy of the facility policy to the client and parent/legal guardian. Acknowledgement, in writing, will be obtained from the client and the parent(s) or legal guardian that he or she has been informed of the facility's policy on the use of restraint during an emergency safety situation. This will occur regardless of the client's age. This acknowledgement is filed in the client's medical record.

B. Physical restraints of Damar Services clients and clients should only be used to ensure safety and protection. Physical restraints and emergency safety interventions should only be employed as a response to an emergency safety situation. The client, other clients, staff members, or others must be at imminent risk of physical harm.

C. As any physical intervention involves some risk of injury to the young person or staff, Damar Services employees must weigh this risk against the risk of imminent physical harm involved in failing to physically intervene when it may be warranted.

D. Physical interventions must never be used as 1) punishment, 2) for demonstrating who is in charge, 3) program maintenance (such as enforcing compliance with directions or rules or 4) for therapeutic purposes (such as forming attachment as promoted by "holding" therapy advocates or inducing regressive states).

E. Physical interventions should only be employed after other less restrictive approaches such as behavior management techniques, protective interventions, or verbal de-escalation have been attempted, unsuccessfully, or where there is no time to try such alternatives.

F. Staff will make every effort to utilize the least restrictive method of physical intervention possible; that is, staff will attempt to utilize standing holds, seated holds and supine restraints. <u>The use of PRONE restraint is not permitted at any Damar Services Program.</u>

G. Staff will initiate physical interventions only when sufficient staff is present; this would include a minimum of 2 staff members for a standing hold or seated hold, and a minimum of 3 staff members for a supine

restraint.

H. Emergency safety interventions/physical restraints must only be employed for the minimum time necessary. They must cease when the client is judged to be safe and no longer at imminent risk of harming themselves or others, or by meeting established behavioral criteria to end the restraint. For children nine (9) years of age and younger, the initial order should not exceed 15 minutes. For individuals then (10) years and older, the initial order should not exceed 30 minutes.

I. Physical interventions may only be undertaken by staff members that have successfully completed the TCI crisis management course.

J. Only physical intervention skills and decision-making processes that are taught in the TCI course may be used. All techniques must be applied according to the guidelines provided in the TCI training and in this policy.

K. When possible, staff members will consult with peers and supervisors prior to initiating any physical intervention.

L. Clients are not permitted to restrain or to assist in the restraint of other clients.

M. A Life Space Interview will occur where a staff member provides the client with an explanation for the intervention and offer the client an opportunity to express his or her views on what transpired. This should occur prior to the client returning to programming.

N. All incidents of physical restraint must be documented on the client's individual progress note for that shift, an ESI packet, and a Damar Services incident report form.

O. If the Authorization for restraint is verbal, the verbal authorization must be given by Clinician on Call while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The Clinician on Call, as permitted by the state and the facility to order restraint, must verify the verbal order in a signed written form in the client's record. The signed verification of verbal orders will occur as soon as possible with the Clinician on Call signing within (preferably) 24 hours or at their next visit to the site, not to exceed seven (7) business days. The Clinician on Call must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention/physical restraint.

P. There may never be a PRN or standing order for restraints.

Q. All incidents of restraint must be documented on the ESI packet and Damar Services incident report form.
    a. The ESI packet includes the following information:
        i. Date of ESI
        ii. Time initiated and time ended
        iii. Type of intervention
        iv. Justification for use
        v. Staff involved in crisis
        vi. Staff involved in intervention
        vii. Triggering events
        viii. Behaviors client was displaying
        ix. Types of interventions used to prevent ESI
        x. Clients response to those interventions
        xi. Length of time staff worked to prevent use of ESI
        xii. Criteria to end seclusion
        xiii. Belongings / items removed for safety
        xiv. Clinical directives for ESI
        xv. 15 minute assessments from staff during ESI
        xvi. Behavior after ESI
        xvii. Post ESI assessment by nurse
        xviii. Notification of guardian and / or referral source

xix. Client debriefing
xx. Staff debriefing

R. Each order for restraint must:

1. Be limited to no longer than the duration of the emergency safety situation;
2. Children 9 years of age and younger is limited to 15 minutes. If it needs extended, a new order must be obtained to continue;
3. Those 10 years of age and older is limited to 30 minutes. If it needs extended, a new order must be obtained to continue;
4. Be limited to no longer than TCI recommendations for that particular restraint technique; and
5. Under no circumstances should a restraint last more than an hour. The initial order from the Clinician on Call should not exceed 30 minutes. If the client is not calmed within 30 minutes, the Clinician on Call must be called to approve up to an additional 30 minutes.

Y-I-01 RESTRAINT AND SECLUSION

essential

Standard

Health staff order *clinical restraints* and *seclusion* only for patients exhibiting behavior dangerous to self or others as a result of medical or mental illness. Except for monitoring their health status, the health staff does not participate in the restraint of juveniles ordered by child care staff.

Compliance Indicators

1. Juveniles are not restrained in a manner that would jeopardize their health.
2. With regard to clinically ordered restraint and seclusion (including time-out):
   a. Policies and procedures specify:
      i. The types of restraints or conditions of seclusion that may be used
      ii. When, where, how, and for how long restraints or seclusion may be used
      iii. How proper peripheral circulation is maintained (when restraints are used)
      iv. That proper nutrition, hydration, and toileting are provided
   b. The least restrictive, appropriate treatment is used.
   c. In each case, use of restraint is authorized by a physician or other qualified health care professional where permitted by law.
   d. Patients placed in clinically ordered restraints should be continuously monitored by health care or child care staff. Youth in seclusion should be monitored irregularly not more than 15 minutes apart. Such checks are documented.
   e. The treatment plan provides for removing patients from restraints or seclusion as soon as possible.
   f. The same types of restraints that would be appropriate for individuals treated in the community are used in the facility.
3. With regard to custody-ordered restraints:
   a. When restraints are used by child care staff for security reasons, health staff are notified immediately in order to:
      i. Review the health record for any contraindications or accommodations required, which, if present, are immediately communicated to appropriate child care staff and responsible health authority (RHA). If health staff are not on duty, the health staff member on call is notified.
      ii. Initiate health monitoring, which continues at designated intervals as long as the juvenile is restrained. If the health of the juvenile is at risk, it is immediately communicated to appropriate child care staff and the RHA.

b. If the restrained juvenile has a medical or mental health condition, the physician is notified immediately so that appropriate orders can be given.
c. When health staff note improper use of restraints that is jeopardizing the health of a juvenile, they communicate their concerns as soon as possible to appropriate child care staff and the RHA.

4. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

Clinical restraint is a therapeutic intervention initiated by medical or mental health staff to use devices designed to safely limit a patient's mobility.

Clinical seclusion is a therapeutic intervention initiated by medical or mental health staff to use rooms designed to safely limit a patient's mobility. Communicable disease isolation is not considered seclusion for the purpose of this standard.

Discussion

The intent of this standard is that when restraints are used for clinical or custody reasons, the juvenile is not harmed by the intervention. (See Y-G-09 Counseling and Care of the Pregnant and Postpartum Juvenile for requirements regarding restraint of pregnant juveniles.)

When clinically ordered restraint or seclusion is used, it is employed for the shortest time possible in keeping with current community practice. Juveniles are not restrained in an unnatural position (for instance, hog-tied, facedown, spread-eagle). All staff who use restraints are trained in their proper application. Examples of typical restraint devices are fleece-lined leather, rubber or canvas hand and leg restraints, two-point and four-point restraints, and restraint chairs. Metal or hard plastic devices (such as handcuffs and leg shackles) are not used for clinically ordered restraint.

Generally, an order for clinical restraint or seclusion is not to exceed 1 hour, but state health code requirements, if applicable, may vary. Health monitoring consists of checks for circulation and nerve damage, airway obstruction, and psychological trauma.

RHAs who do not permit use of clinically ordered restraints or seclusion generally transfer patients to a local emergency room or another juvenile correctional facility equipped to offer such interventions.

This standard reflects a number of findings and assumptions:

Alignment

2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
Programs strive to avoid the use of seclusion and restraint, and only resort to using either intervention as a last recourse to de-escalate aggressive or life-threatening behavior toward self or others.	**The *Nonviolent Crisis Intervention*® training program focuses on preventative techniques to avoid the use of restraint and seclusion by equipping staff with strategies to intervene through verbal and nonverbal means to create a respectful environment promoting *Care, Welfare, Safety, and Security*℠.**
Definition of Restraint: The use of physical, mechanical, or other means to temporarily subdue an individual or otherwise limit a person's freedom of movement. It is used when there is an immediate risk of harm to self or others, and it is determined as the only means to de-escalate the threatening behavior.	**The *Nonviolent Crisis Intervention*® training program provides instruction in the use of CPI *Personal Safety Techniques*℠ and physical restraint techniques. The restraint techniques are viewed as emergency procedures to be used as a last resort, only when an individual is an imminent danger to self or others.**
Standard 2.F.1: The organization has a policy that identifies whether or not: a. It will use emergency intervention in response to assault or aggression. b. Seclusion or restraint is used within the programs it provides.	**CPI recommends that all facilities develop policies and procedures addressing behavior management, restraint, and seclusion. Facilities should ensure policies and procedures are in compliance with applicable state and federal laws, as well as appropriate regulatory bodies such as CARF. CPI's Instructor Services can help organizations develop new policies and procedures or improve existing policies and procedures.**
Standard 2.F.2: Procedures for the use of emergency intervention, seclusion, or restraint include protocols for: a. Adults. b. Children and adolescents. c. Persons with special needs.	**The *Nonviolent Crisis Intervention*® training program teaches several personal safety techniques and restraint techniques. Staff are instructed to choose the appropriate techniques to respond to the emergency while considering the needs of the particular person in crisis such as age, size, and special needs.**

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2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
Standard 2.F.3: In the event that a physical hold is used as a time-limited emergency measure until the appropriate law enforcement, safety, or other emergency service providers arrive on site, the organization implements policies and procedures that:	
a. Identify the emergency circumstances under which a physical hold will be used.	**a. CPI recommends that physical restraint only be used as a last resort when the individual is a danger to self or others and alternative intervention strategies are not effective in resolving the situation. Because all physical interventions involve a level of risk, these methods are to be used only when the risks associated with the acting-out behavior are greater than the risks inherent in the use of physical intervention.**
b. Provide staff training on de-escalation and safe physical management. c. Direct that the emergency intervention procedure is restricted to time-limited, approved physical holds by designated, trained, and competent personnel.	**b./c. Prevention and de-escalation are the primary focus of the *Nonviolent Crisis Intervention*® training program. Safe physical management (*Nonviolent Physical Crisis Intervention*℠) is taught as well. Physical intervention is to be discontinued at the earliest possible moment when the individual is no longer a danger to him/herself or others. The goal of all physical intervention is to protect the individual in crisis and assist him/her in regaining self-control.**
d. Identify the process by which law enforcement, safety, or other emergency service providers will be summoned.	**d. The *Nonviolent Crisis Intervention*® training program instructs participants in recognizing when additional assistance is needed. CPI further recommends that this be detailed in policies and procedures.**
e. Provide a review for continued need for the physical hold every 15 minutes. f. Limit the time for which the physical hold may be used to the time that it takes for law enforcement, safety, or other emergency service providers to arrive (however, not to exceed 45 minutes).	**e./f. CPI recommends that restraints be continually monitored for appropriate use and be discontinued at the earliest possible moment when the individual is no longer a danger to him/herself or others or when staff monitoring the restraint identify signs of physical or psychological distress. CPI recommends all facilities develop policies and procedures that comply with applicable federal and state laws, as well as appropriate regulatory bodies such as CARF.**
g. Provide for the ongoing observation of the person in the physical hold by at least one additional person.	**g. The *Nonviolent Crisis Intervention*® training program includes information on the duties of the Auxiliary Team Members. These additional team members, not involved in the restraint, will provide ongoing observation of the physical and psychological status of the individual in crisis.**

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2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
Standard 2.f.4: If the organization uses seclusion or restraint, there are policies and procedures governing its use that specify that:	
a. Seclusion or restraint is used only for intervention in an individual's emergency situation and to prevent harm to him/herself or others.	**a. CPI's restraint techniques are taught only as a last resort, when other less-restrictive interventions have failed and the individual is a danger to him/herself or others.**
b. Appropriate interaction with staff occurs as an effort to de-escalate the crisis.	**b. The CPI *Crisis Development Model*℠ identifies different behavior levels of a crisis situation. The model also gives examples of how staff can appropriately and effectively respond to each level of a crisis situation.**
c. The medical history of the person served is reviewed to determine whether seclusion or restraint can be administered without risk to health and safety.	**c. All individuals served should have documented medical histories on site. Staff should be made aware of any conditions which may contraindicate the use of restraint in any individual served.**
d. When possible the behavioral health history of the person served is reviewed for identification of prior trauma.	**d. Behavioral health histories for each individual should be reviewed for any sort of trauma which may contraindicate the use of restraint. Prior traumatic experiences may lead to psychological distress when an individual is restrained or secluded.**
e. The use of seclusion or restraint is ordered by a physician or designated, trained, and competent qualified behavioral health practitioner.	**e. Seclusion or restraint should be ordered by a trained and competent qualified behavioral health practitioner familiar with the type of restraints being used and the risks of those restraints.**
f. Seclusion or restraint is administered in a safe manner, with consideration given to the physical, developmental, and abuse history of the person served.	**f. CPI's restraint techniques are designed to be as safe as possible, and can be used effectively on clients with various physical, developmental, and abuse histories. CPI stresses the importance of reviewing patient history for conditions that would contraindicate the use of restraint.**
g. Seclusion or restraint is administered by behavioral health personnel who are trained and competent in the proper techniques of applying and monitoring the form of seclusion or restraint ordered. h. When physical, mechanical, or material restraints are used, personnel are trained, qualified, and competent to administer them.	**g./h. CPI requires all Certified Instructors to demonstrate their competencies in teaching the physical components of our program. In turn, Certified Instructors may use competency-based testing to ensure their staff are correctly administering restraints in the safest way possible. *Nonviolent Crisis Intervention*® training also includes extensive information on how to monitor an individual in a restraint for signs of physical and psychological distress.**
i. When seclusion is used, personnel are trained to monitor for the unique needs of a person in seclusion.	**i. The restraint monitoring techniques taught in *Nonviolent Crisis Intervention*® training can be applied to monitoring an individual in seclusion.**

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2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
j. Removal from seclusion or restraint occurs as soon as the threat of harm has been safely minimized.	**j. CPI teaches that restraints must be released as soon as an individual is no longer a danger to him/herself or others.**
k. Seclusion or restraint is not used as coercion, discipline, convenience, or retaliation by the personnel in lieu of adequate programming.	**k. CPI teaches that restraint should only be used as a last resort, when an individual is a danger to him/herself or others, and other less-restrictive interventions have been ineffective. Restraint should never be used as coercion, discipline convenience, retaliation, or any reason other than to protect the individual or others from imminent harm.**
l. Standing orders are not issued to authorize the use of seclusion or restraint.	**l. Because CPI teaches that restraint should only be used as a last resort in emergency situations, CPI does not support standing orders on the use of restraint.**
m. Contributing environmental factors that may promote maladaptive behaviors are identified and actions taken to minimize those factors.	**m. The *Nonviolent Crisis Intervention*® training program discusses Precipitating Factors, underlying factors (environmental or otherwise) that may precipitate escalating behaviors. Certified Instructors are also taught to problem-solve how to minimize these factors.**
n. Procedures for the use of seclusion or restraint are explained to and discussed with each person served in a manner that is understandable to him or her.	**n. CPI recommends that organizations include a method of informing service users of restraint and seclusion practices in their policies and procedures.**
o. There is documentation that the person served has been consulted regarding alternatives he or she prefers prior to the use of seclusion or restraint, when possible.	**o. CPI recommends that staff be made aware of any mental health advance directives or other documentation regarding preferences prior to the need to implement restraint or seclusion. Certified Instructors can incorporate common preferences in training, and can inform staff of where these documents are located.**
p. The simultaneous use of seclusion and restraint is prohibited unless a staff member has been assigned for continual face-to-face monitoring.	**p. Because of the risks inherent in restraint and seclusion, CPI advocates for face-to-face monitoring any time restraint or seclusion is used.**
q. The physical plant can safely and humanely accommodate the practice of seclusion or restraint.	**q. CPI recommends that all facilities survey their site for any environmental or physical factors which may be unsafe when utilizing restraint or seclusion during a crisis situation.**

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2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
Standard 2.F.5: The procedures for the use of seclusion or restraint adhere to the following:	
a. Documentation demonstrates that all less restrictive intervention techniques were used prior to the use of seclusion or restraint.	**a. The *Nonviolent Crisis Intervention*® training program discusses documentation of incidents, and recommends that all less-restrictive interventions are documented. CPI also has additional resources available to Certified Instructors on how to effectively and comprehensively document incidents.**
b. A designated, qualified, and competent physician or licensed independent practitioner provides face-to-face evaluation of the person served within one hour of the order for seclusion or restraint being given.	**b. CPI recommends that organizations include medical evaluation requirements, in line with state and federal laws and accrediting body standards, in organizational policies and procedures.**
c. An order for seclusion or restraint is time limited and does not exceed four hours for an adult. For a child or adolescent, the order does not exceed one hour. d. Orders for seclusion or restraint may be renewed for a total of up to 24 hours. Orders for renewal may only occur following a face-to-face assessment by a designated, trained, and competent qualified behavioral health practitioner. e. After 24 hours, a new order is required following a face-to-face evaluation by a designated, qualified, and competent physician or licensed independent practitioner.	**c./d./e. Restraint and seclusion should be discontinued as soon as safely possible. Organizations should check with state and federal regulations, as well as with accrediting body standards, for time limits on the use of restraint and seclusion and renewal orders. Organizations should then include this information in their policies and procedures.**
f. Appropriately trained personnel continually assess, monitor, and re-evaluate the person served to determine whether seclusion or restraint is still needed.	**f. The *Nonviolent Crisis Intervention*® training program teaches participants to monitor for physical and psychological distress in individuals being restrained. *Nonviolent Crisis Intervention*® training also teaches participants how to recognize when restraint or seclusion is no longer needed.**
g. All orders are entered into the record of the person served as soon as possible but not more than two hours after implementation. h. The designated and qualified personnel sign the order within the time period mandated by law.	**g./h. Documentation is a key aspect of the *Nonviolent Crisis Intervention*® training program. CPI recommends that all documentation of incidents take place as soon as possible.**
i. Face-to-face attention, including attention to vital signs and the need for meals, liquids, bathing, and use of the restroom, is given to a person in seclusion or restraint at least every 15 minutes by authorized personnel.	**i. The philosophy of the *Nonviolent Crisis Intervention*® training program is *Care, Welfare, Safety, and Security*℠. To keep in line with the philosophy of the program, CPI recommends that all individuals served continuously receive proper monitoring of vital signs and other needs.**
j. Documentation of re-evaluations and face-to-face attention is entered into the record.	**j. See the importance CPI places on documentation in g./h.**

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2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
k. The family of the person served is notified, if applicable and permitted, as soon as possible but at least within eight hours of the initial use of seclusion or restraint.	**k. CPI recognizes the need to keep a client's family members informed of his/her behavior. CPI has resources available for Certified Instructors containing information specifically tailored to parents and other family members. CPI has found that informing parents and other family members of and involving them in behavioral intervention plans is beneficial to the individual served, the family, and to staff.**
Standard 2.F.6: The use of seclusion or restraint always: a. Is documented as an incident. b. Results in a review, and, as appropriate, revision of the treatment plan or program model for the person served.	**a./b. The CPI *COPING Model*℠ offers a debriefing model to be used to review a crisis incident. The model provides a process for documenting the incident, establishing the facts about the incident, and evaluating the facts to identify patterns in behavior. The model also requires that staff investigate the alternatives to the current treatment plan or program to minimize the occurrence of the acting-out behavior.**
Standard 2.F.7: Following the use of seclusion or restraint, the person served, his or her family, when appropriate, and personnel discuss the reasons for the use of seclusion or restraint. The discussion is documented and addresses: a. The incident. b. Its antecedents. c. The reasons for the use of seclusion or restraint. d. The person's reaction to the intervention. e. Actions that could make future use of seclusion or restraint unnecessary. f. When applicable, modifications made to the treatment plans to address issues or behaviors that impact the need to use seclusion or restraint.	**Following the physical restraint (or even a crisis that is de-escalated without restraint), the *Nonviolent Crisis Intervention*® training program teaches staff to utilize the CPI *COPING Model*℠, which provides a structure for reviewing the episode with both the person in crisis and staff members involved. This model may also be used to debrief with witnesses and to inform family members. The CPI *COPING Model*℠ allows for orienting and establishing the facts of the incident from the clients' perspective. Patterns of past behavior and triggers of the behavior for the person served, as well as staff responses are examined. Individuals served assist in defining alternatives to the inappropriate behavior and identifying resources that can be helpful in making behavioral change. Changes to treatment plans are agreeded upon by staff and the individual served.**
Standard 2.F.8: The chief executive or designated management staff member reviews and signs off on all uses of seclusion and restraint after every occurrence.	**CPI recommends that the organization's administration receive *Nonviolent Crisis Intervention*® training. This will allow management to effectively review all incidents of seclusion and restraint.**
Standard 2.F.9: The use of seclusion or restraint is recorded in the information system and reviewed for: a. Analysis of patterns of use. b. History of use by personnel. c. Environmental contributing factors. d. Assessment of program design contributing factors.	**CPI recommends post-incident debriefing and data collection to assist in identifying patterns in staff responses and environmental and program design contributors to incidents of restraint and seclusion.**

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2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
Standard 2.F.10: If the frequency of the use of seclusion or restraint changes, the chief executive or a designee investigates the pattern of use and takes action to continuously reduce or eliminate the use or seclusion or restraint.	**The *Nonviolent Crisis Intervention*® training program teaches that after each use of restraint or seclusion, a client's behavioral plan should be reviewed to investigate patterns and ways to eliminate future occurrences of restraint or seclusion.**
Standard 2.F.11: All personnel involved in the direct administration of seclusion or restraint receive initial and ongoing competency-based training in the following:	
a. The contributing factors or causes of threatening behavior. b. Which chemical conditions may contribute to aggressive behavior. c. How the interactions of personnel may impact the behaviors of persons served.	**a./b./c. The *Nonviolent Crisis Intervention*® training program specifically addresses identification of warning signs and Precipitating Factors, promotes the understanding of unique circumstances of each individual, and discusses how staff behaviors and responses may impact the behaviors of individuals served.**
d. The use of alternative interventions, such as mediation, de-escalation, self-protection, and time-out.	**d. Prevention and de-escalation are the primary focus of *Nonviolent Crisis Intervention*® training. Self-protection is also an important component.**
e. Recognizing signs of physical distress in the person who is being restrained or secluded.	**e. Unit VIII outlines the duties of the Auxiliary Team Members. One of these duties is monitoring for signs of physical distress in the person being restrained. The *Nonviolent Crisis Intervention*® Instructor Manual includes a chart outlining signs of distress to be monitored for during the use of restraint or seclusion.**
f. The re-establishment of communication after a person has been secluded or restrained.	**f. A key component of the program is re-establishing the therapeutic relationship with the client after the incident, which is discussed in the unit on Postvention.**
g. The prevention techniques of threatening behaviors.	**g. Prevention is a primary focus of the *Nonviolent Crisis Intervention*® training program.**
h. When and how to restrain or seclude safely.	**h. *Nonviolent Physical Crisis Intervention*℠ teaches restraint techniques to be used as a last resort.**
i. Training on how to monitor and continually assess for the earliest release.	**i. The Team Leader and Auxiliary Team Members continuously monitor for earliest release. Team Leader and Auxiliary Team Member duties are described in the unit on team intervention.**
j. The practice of intervention done by a team.	**j. The *Nonviolent Crisis Intervention*® Instructor Manual includes practical information on team intervention. CPI also recommends that those individuals implementing restraint practice as a team during training under the supervision of a Certified Instructor.**

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2006 CARF Behavioral Health Standards Manual: Section 2.F. Seclusion and Restraint	*Nonviolent Crisis Intervention*® Training Program
k. The practice of intervention done by an individual.	**k. Unit VIII includes a lecture on intervening alone versus with a team. Staff members are taught to summon a team, but are also instructed in CPI's *Personal Safety Techniques*℠. The CPI *Interim Control Position*℠ can be used for a brief period of time when waiting for team arrival.**
Standard 2.F.12: Training is provided by persons or entities who are certified to conduct such training.	**CPI certifies Instructors, who in turn, may train other employees within their facilities (train-the-trainer program).**
Standard 2.F.13: When a team intervention is conducted, written procedures are available for: a. Defining team leadership. b. Assigning team duties.	**The *Nonviolent Crisis Intervention*® training program includes a unit on team intervention which clearly defines Team Leader duties, including assigning duties to other team members. Auxiliary Team Member duties are also defined.**
Standard 2.F.14: If an advance directives plan or crisis intervention plan exists for the person served, it is readily available for immediate reference.	**CPI recommends that this requirement is addressed in policies and procedures and that all staff are made aware of where these plans are located.**
Standard 2.F.15: A room designated for the use of seclusion or restraint has: a. Adequate air flow. b. An identified plan for emergency exit. c. Access to bathroom facilities. d. Sufficient lighting. e. Observation availability.	**Because requirements on this topic vary from state to state, CPI recommends that each organization develop policies and procedures related to these requirements that are in compliance with applicable federal and state laws, as well as with appropriate regulatory bodies such as CARF.**

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Behavior Support and Management

INTRODUCTION

Effective behavior support and management practices center around preemptive interventions, such as identifying challenging behaviors and working with the service recipient and their support systems to create practical solutions in order to minimize the need for crisis interventions (including, but not limited to, restrictive interventions) to the greatest extent possible. A culture that promotes respect, healing, and positive behavior, and provides individuals with the support they need to manage their own behaviors, can help prevent the need for crisis interventions. Involving the service recipient and appropriate family members or support systems early on, by identifying triggers and previous successes in coping with escalating behaviors creates a collaborative approach to behavior support management and helps provide personnel and the individual early insight to challenging behaviors. Training for personnel is an essential component of maintaining a safe work and service environment. Training also prevents injuries and deaths in crisis situations, including those that warrant the use of restrictive interventions as a last resort. Organizations that maintain a process for reviewing incidents when they do occur have the opportunity to make changes in their practices to support the safest environment possible and further reduce the use of restrictive interventions.

Interpretation: *Throughout these standards, the phrase "crisis interventions" and "challenging behaviors" are used. Challenging behaviors refers to harassing, violent, or out of control behaviors that threaten the safety of oneself or others. Crisis intervention include restrictive interventions or, for organizations that prohibit such interventions or other "last resort" options (e.g., calling the police or removing the individual from the program). When the standards are addressing restrictive interventions, it will be explicit and the standard will have an NA for organizations that prohibit restrictive interventions.*

Interpretation: *Timeout or isolation are colloquial terms that may or may not include restrictive interventions. For the purpose of these standards, any instance where a service recipient is placed in a room separate from others and cannot voluntarily leave said room (whether the door is locked or staff is preventing the individual to leave) will be referred to as seclusion and considered a restrictive intervention.*

Research Note: *The challenging behaviors that invoke crisis interventions are often times rooted in the individual's personal trauma and crisis interventions, whether or not they are restrictive, run the risk of retraumatizing the individual. The literature on trauma informed care*

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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identifies six core strategies for reducing the need for crisis interventions: leadership toward organizationl change, use of data to inform practice, workforce development, use of restraint and seclusion reduction tools, improved the service recipient's role, and debriefing techniques.

Note: *All organizations are required to complete BSM 1, BSM 2, and BSM 3. Any service that uses isolation, manual or mechanical restraint, and/or locked seclusion in facilities. BSM 4, BSM 5, and BSM 6 are not applicable in organizations that prohibit the use of restrictive behavior management interventions. Restrictive behavior management interventions are those that restrict, limit, or curtail a person's freedom of movement and include isolation, manual restraint, mechanical restraint, and locked seclusion. Related definitions can be found in COA's glossary.*

Note: *BSM does not apply to FEC programs, but in organizations providing multiple services, including FEC, the Standards will apply and must be implemented in the non-FEC programs.*

Note: *Organizations that permit foster homes to employ manual restraints will complete all the standards in this section, as applicable, as well as FKC 20.*

Note: *Organizations that work with populations with developmental delays and utilize protective clothing, such as protective helmets, will address those intervention in CR 4.05 and TS 5.02.*

Note: *Restrictive interventions are those involuntarily restrict, limit, or curtail a person's freedom of movement and include manual restraint, mechanical restraint, and seclusion. Federal guidelines consider any restriction of an individual's movement a restrictive intervention. Related definitions can be found in COA's glossary.*

Note: *Some organizations serving youth involved with the juvenile justice system and accredited under COA's Juvenile Justice Residential Services (JJR) service system may lock youth in their rooms for routine purposes (e.g., during sleep periods), as opposed to in response to an incident. Although this practice does restrict a person's freedom of movement, it differs from the types of restrictive behavior management interventions addressed in this section insofar as it is utilized on a routine, ongoing, basis, rather than in response to a specific incident. Accordingly, this practice is addressed in JJR 15, and standards referencing "seclusion," or "restricted behavior management interventions" do not apply.*

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Behavior Support and Management

Note: *Please see BSM Reference List for a list of resources that informed the development of these standards.*

Table of Evidence

Self-Study Evidence

- Describe your organization's approach to behavior support and management and how it is implemented in practice to promote positive behavior (e.g., Our organization operates a residential treatment program for adjudicated youth who have a history of violence and aggressive behavior. We have taken the following steps to promote a positive, therapeutic environment and ensure the safety of our service recipients and staff...).
  a. Include the full spectrum of behavioral support interventions that your organization utilizes (e.g., point programs, level systems, time out, manual restraint, etc.).
  b. If your organization uses any restrictive interventions (e.g., manual restraint, seclusion, and mechanical restraint), provide your organization's rationale for their use.
- Does your organization use restrictive behavior management under any circumstances?
- Identify a part of your behavior support and management policies and practices that have been:
  a. the most difficult to advance, and indicate the reasons why; and
  b. the least difficult to advance, and indicate the reasons why (e.g., Changes in state regulations have increased the number of adolescents admitted with a history of sexually acting out behavior. Consequently, we've had to modify our behavior support and management practices to include...).
- Does your organization use any established behavior support and management interventions, e.g., The Therapeutic Crisis Intervention System (TCI)?
- Provide any additional information about your organization's behavior support and management policies and procedures that would increase the Peer Team's understanding of how the practice(s) support a safe environment and reduce the need for restrictive interventions.

On-Site Evidence

No On-Site Evidence

On-Site Activities

No On-Site Activities

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Behavior Support and Management

(FOC) BSM 1: Philosophy and Organization Policy

The organization's governing body and management promote a safe and therapeutic environment and provide necessary supports and resources to:

a. keep staff and service recipients safe;
b. enhance the service recipient's quality of life;
c. teach, strengthen, and expand upon positive behaviors; and
d. minimize the use of crisis interventions.

Related: OST 3

Interpretation: *For organizations that permit restrictive interventions, minimizing the use of interventions includes prioritizing a reduction in restraints/seclusions. For organizations that prohibit the use of restrictive interventions, this would result in reduction in the application of their crisis plans or "last resort" interventions (e.g. removing the individual from the program or calling the police).*

Research Note: *Research shows that leadership and organizational policy place a significant role in the reduction of crisis interventions and in creating more trauma informed-care. By developing policies that emphasizes a reduction in crisis interventions and using pre-identified, individualized means of de-escalation a more therapeutic environment can be developed.*

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

Rating Indicators

1) The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 1 Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 1 Practice standards.

3) Practice requires significant improvement, as noted in the ratings for the BSM 1 Practice standards.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 1 Practice standards.Â

Table of Evidence

Self-Study Evidence

- A description of the organization's BSM philosophy in BSM Narrative Question 1 including:
  a. programmatic and preventive approaches

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b. the spectrum of BSM interventions
c. procedures/ interventions prohibited by the organization
- BSM policy and procedures
- Incident review procedures

On-Site Evidence

- For organizations using restrictive behavior management interventions, provide documentation of clinical director notification of restrictive behavior management interventions
- Documentation of compliance with applicable laws or regulations

On-Site Activities

- Interview:
  a. Clinical or program directors
  b. Supervisors
  c. Personnel
  d. Persons served
  e. Parents/legal guardians

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

BSM 1.01

The organization's behavior support and management policies and practices comply with federal, state, and local legal and regulatory requirements.

Interpretation: *The Public Health Service Act, as amended by the Children's Health Act of 2000 and the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services to Individuals Under Age 21 are federal regulations that govern the use of behavior management in the United States. Organizations serving youth involved with the juvenile justice system may be subject to different laws and regulations.*

Research Note: *Per the federal standards, deaths must be reported promptly. Facilities must also report to agencies designated by the Secretary of the Department of Health and Human Services each death that occurs while a resident is restrained or in seclusion and each death that occurs within 24 hours after the person has been released from the restraints and seculsion or where it is reasonable to assume the death was the result of the restraints and seclusion. The designated agencies are likely to include protection and advocacy systemes, which have unique federal authority to investigate and legally pursue instances of abuse and neglect in facilities. The notification must be provided within 7 days of the death of the*

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individual.

Note: *COA recognizes that the laws or regulations governing organizations serving youth involved with the juvenile justice system may sometimes authorize practices that conflict with the standards to which COA holds other organizations, and has addressed some of the potential discrepancies throughout the standards in BSM.*

Note: *The organization is required to comply with the more stringent standard or regulation.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- The organization generally complies with all legal and regulatory requirements, with only minor exceptions noted in reports.

3) Practice requires significant improvement; e.g.,

- The organization does not comply with requirements in at least one major area and is remedying this under the direction of appropriate authorities.

4) The organization has a pervasive problem of non-compliance.

- Implementation of the standard is minimal or there is no evidence of implementation at all.

BSM 1.02

Behavior support and management policies address:

a. practices used to maintain a safe environment and prevent the need for crisis interventions;
b. the use of individualized, proactive interventions to identify challenging behaviors, their antecedents, and how to help the service recipient cope and de-escalate;
c. safety measures to be taken when crisis situations arise, including whether isolation, locked seclusion, manual or mechanical restraint are permitted as emergency safety measures or, when prohibited, other crisis intervention strategies;
d. other practices that may be used and under what circumstances; and
e. prohibited practices, including chemical restraint when the organization is responsible for medication administration.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Behavior Support and Management

Related: BSM 2.02, FKC 7.06, FKC 19.06

Interpretation: *In regards to element (c), organizations that do not permit any of the restrictive interventions listed should address procedures for when de-escalation techniques do not work and the service environment no longer remains safe for the individual or others (e.g. removal from program or calling the police).*

Interpretation: *In relation to element (e), chemical restraint does not include situations when a psychopharmacological drug:*

a. *is used according to the requirements for treatment authorized by a court; or*
b. *is provided using specified criteria in a person's approved treatment plan as per a physician's order to provide medical treatment for a specific diagnosis and known progression of symptoms, such as in cases of a PRN; or*
c. *is administered in an emergency to prevent immediate, substantial, and irreversible deterioration of a person's mental status when prescribed by a physician or other qualified medical practitioner.*

Medications are treatment for targeted symptomtology and should not be considered an intervention for challenging behaviors. Other prohibited practices include, but are not limited to, corporal punishment, behavioral control methods that interfere with the individual's right to human care, etc.

Interpretation: *Organizations serving youth involved with the juvenile justice system may also be legally authorized to use restrictive interventions to prevent escapes, or protect property, in order to maintain safety, security, and order. However, they should still only employ restrictive interventions when absolutely necessary, as referenced throughout these standards.*

Note: *For organizations that have resource parents providing restrictive interventions, those standards can be found throughout FKC, however the organization needs to clearly outline in the policy the interventions resource parents are permitted to apply and under what circumstances.*

Note: *Refer to COA's glossary for a definition of chemical restraint.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- One of the elements needs greater specificity or clarity in policy and/or procedures.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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3) Practice requires significant improvement; e.g.,

- Two of the elements need greater specificity or clarity in policy and/or procedures; Â or
- Policies and/or procedures are too vague to provide guidance to personnel.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

- One of the elements is not implemented.

BSM 1.03

A committee comprised of all levels of staff conducts regular reviews of the use of behavior support and management interventions and:

a. compare how organization practices compare with current information and research on effective practice;
b. use findings from quarterly risk management reviews of crisis interventions to inform staff about current practice and the need for change;
c. revise policies and procedures when necessary;
d. determine whether additional resources are needed; and
e. support efforts to minimize the use of crisis interventions.

Related: PQI 4.03

Interpretation: *For organizations that prohibit restrictive interventions, information regarding staff's response to crisis situation should still be collected and reviewed, including the frequency of using last resort intervention (e.g., removal from program or calling the police).*

Interpretation: *Element (d) should include considerations for continuing staff training and education, when appropriate.*

Research Note: *Agreement has been reached among experts that the best way to reduce injuries and deaths is to minimize the use of restraints to the greatest extent possible, with leadership creating a shared vision in order to adopt organization wide policies. Reductions in the use of seclusion and restraint can improve both staff morale and treatment outcomes by mitigating burnout, lower staff turnover, and avoid traumatization and retraumatization.*

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Behavior Support and Management

Research Note: *Using data on crisis interventions and their outcomes is helpful in monitoring the progress of organization towards achieving overall treatment outcomes and identifying when more supportive resources are needed. One form of analyses that may be effective to use during regular review is root cause analysis, a systematic process for identifying root cuases of problems or events and an approach for responding to them. It acknowledges that prevention is often not achieved with a single intervention and strives for continuous improvement. This form of analysis is particularly well-suited for behavior support management due to its complex nature and need for re-evaluation on both an individual-level and organization wide.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- One of the elements needs to be reviewed more regularly; Â or
- Elements (a) or (e) is not consistently done.

3) Practice requires significant improvement; e.g.,

- Two of the elements are not reviewed regularly ; or
- Reviews are not done sufficiently often to monitor practices.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,Â

- Three of the elements are not reviewed regularly.

BSM 1.04

The program or clinical director is notified following each use of a crisis intervention, including seclusion or manual or mechanical restraint, and each incident is administratively reviewed no later than one working day following an incident.

Interpretation: *The review includes examining any preemptive measures taken to avoid crisis interventions, whether or not the individual's behavior support and management plan was followed, and the measures' effectiveness.*

Interpretation: *For organizations that permit restrictive behavior management, this would include each use of seclusion or manual or*

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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mechanical restraint. For organizations that prohibit restrictive behavior management, this would include strategies utilized in response to crisis interventions, such as calling the police or removal from the program.

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Notification and administrative review regularly occur, however procedures need clarifying; or
- Notification has occasionally exceeded one working day.

3) Practice requires significant improvement; e.g.,

- There have been instances where notification or administrative review did not occur; or
- Procedures need significant strengthening.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- Notification or review does not regularly occur.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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(FOC) BSM 2: Behavior Support and Management Practices

A culture and structure exists within every facility that promotes respect, healing, and positive behavior of the service recipient and prevents the need for crisis interventions.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

Rating Indicators

1) The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 2 Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 2 Practice standards.

3) Practice requires significant improvement, as noted in the ratings for the BSM 2 Practice standard; and/or

- One of the BSM 2 Fundamental Practice Standards received a 3 or 4 rating.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 2 Practice standards; and/or

- Two or more of the BSM 2 Fundamental Practice Standards received a 3 or 4 rating.

Table of Evidence

Self-Study Evidence

- Copy of written behavior support and management philosophy and procedures provided to service recipients and/or parents/legal guardians
- Procedures that address harassment and violence towards other service recipients and personnel
- Protocol for obtaining consent
- Procedures for conducting organization-wide assessments regarding behavior management support and management interventions and related reports
- For organizations using restrictive behavior management interventions, procedures for developing behavior management plans

On-Site Evidence

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- Protocol for notifying parents/guardians of incidents and use of restrictive interventions

On-Site Activities

- Interview:
  a. Parents/legal guardians
  b. Persons served
  c. Relevant personnel
- Case record review

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

BSM 2.01

Personnel support positive behavior by:

a. developing positive relationships with service recipients;
b. being trauma-informed;
c. building on strengths and reinforcing positive behavior; and
d. responding with appropriate consistency to all incidents that challenge the safety of service recipients.

Related: BSM 3.02, JJR 8.02, JJR 13.02, FKC 19.06, PA-CFS 25.05

Note: *Staff training on the organization's approach to promoting positive behavior is addressed in BSM 3.02.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- One of the elements is not fully addressed but training is being offered to personnel.

3) Practice requires significant improvement; e.g.,

- Two of the elements are not fully implemented and training is not sufficient or consistently provided.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- One of elements is not addressed at all.

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(FP) BSM 2.02

The organization prohibits the use of restrictive interventions:

a. by service recipients, peers, or any person other than trained, qualified staff;
b. as a form of punishment or discipline;
c. for the convenience of staff;
d. in response to property damage that does not involve imminent danger to self or others; and
e. when contraindicated in the individual's service or behavior plan.

Related: BSM 1.02, RTX 1.03, GLS 1.03, MHSU 1.03, PSR 1.03, JJD 3.03, JJR 3.03, WT 4.03, BSM 5, DTX 5.03, DDS 5.03

Interpretation: *As referenced in BSM 1.02, organizations serving youth involved with the juvenile justice system may also be authorized to use restrictive interventions to prevent escapes or protect property, but should only do so when absolutely necessary, as referenced throughout these standards.*

NA *The organization prohibits the use of restrictive behavior management interventions.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- There have been a few instances of prohibited interventions, but corrective action was implemented immediately.

3) Practice requires significant improvement; e.g.,

- There have been a few instances of prohibited interventions, and no evidence of immediate and appropriate corrective action.

4) One or more of the prohibited intervention is consistently being used.

(FP) BSM 2.03

The organization:

a. provides an explanation for and offers a copy of its written behavior support and management philosophy and procedures to service recipients or their parents or legal guardians at admission;

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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b. informs service recipients or parents or legal guardians of strategies used to maintain a safe environment and prevent the need for restrictive behavior management interventions;
c. obtains the service recipient's or parent's or legal guardian's consent when restrictive behavior management interventions are part of the treatment modality; and
d. when the service recipient is a minor, notifies the parents or legal guardians promptly when the minor is involved in an incident involving harassment or violence or when a restrictive intervention was used.

Interpretation: *COA recognizes that it may be difficult for organizations providing residential juvenile justice services to involve youths' parents or legal guardians, especially when youth are placed outside of their communities and far from their families; however, organizations should still strive to involve families to the extent possible. In any instance when promptly notifying parents or legal guardians in the wake of an intervention proves difficult, the organization should document its efforts to initiate contact in the case record. See JJR 4.03 for guidance on ways to minimize barriers to family participation.*

Interpretation: *Consent should be reviewed on an annual basis. The service recipient, and/or parent or legal guardian, has the right to refuse consent to treatment and the organization may determine that the individual cannot be served as a result of refusal. When an organization serves youth involved with the juvenile justice system and services are involuntary, obtaining consent may not be relevant.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Procedures need minor clarification; or
- One of the required elements is not fully addressed.

3) Practice requires significant improvement; Â e.g.,Â

- Two of the elements are not fully addressed; or
- One element is not addressed at all; or
- Annual consents as delineated in the interpretation are not consistently obtained; or
- Parents or legal guardians are frequently not notified.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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- Three or more of the elements are not fully addressed; or
- Two of more of the elements are not addressed at all.

(FP) BSM 2.04

The organization conducts an organization-wide assessment of its service population to determine the potential risk and appropriate crisis interventions to employ.

Related: JJD 1.02, JJR 1.04, FKC 2.01, RPM 2.02, JJR 2.04

Interpretation: *An organization-wide assessment includes, but is not limited to, descriptive statistics of the service population, their needs, services provided, and risks associated with serving them; reviewing data on the use of behavioral intervention or crisis response in the past year; as well as the annual critical incident reports and any corrective action taken in response. The resulting report should clearly describe the service population and the organization's behavior and support management needs.*

Note: *Organizations can include reports and data aggregates they create in RPM 2.02, elements b-e, or information about service recipients they receive through the screening and intake process.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- The screening assessment needs clarifying.

3) Practice requires significant improvement; e.g.,

- Screening practices are not consistently done for all clients; or
- The organization prohibits the use of restrictive behavior management interventions but does not conduct a program- wide assessment as delineated in the interpretation.

4) The organization does not prohibit the use of restrictive behavior management interventions and each service recipient does not have a screening and/or have documentation of a screening in the case record.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

(FP) BSM 2.05

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Behavior Support and Management

Organizations utilizing restrictive behavior management interventions collaborate with the service recipient and/or parents or legal guardian to assess for:

a. the individual's perception of emotional and physical safety;
b. past experiences with restrictive behavior management interventions;
c. antecedents, emotional triggers, and the resulting challenging behaviors;
d. previous successes in utilizing strategies and coping skills to mitigate need for restrictive behavior management interventions;
e. psychological and social factors that can influence use of such interventions, including trauma history; and
f. medical conditions or factors that could put the person at risk.

Related: JJD 1.02, JJR 1.04, FKC 2.01, RTX 12.05

Interpretation: *Medical factors may include issues related to use of medications, such as an insulin imbalance. Psychological and social factors may include psychosis, history of abuse or other trauma, or claustrophobia.*

Interpretation: *This standard is typically related to BSM 2.04. However, when organizations serving youth involved with the juvenile justice system also use restrictive behavior management interventions for other purposes (such as to prevent escapes during transport), any youth who might be subject to these interventions should be assessed for the factors listed in this standard, regardless of whether the screening addressed in BSM 2.04 indicates risk of harm to self or others.*

Research Note: *A common traumatic element is the massive control of one person over another. For individuals with a history of abuse or other trauma, undergoing a restrictive behavior management intervention can be extraordinarily retraumatizing.*

NA *The organization prohibits the use of restrictive behavior management interventions.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Procedures need clarifying or do not adequately address one of the elements.

3) Practice requires significant improvement; e.g.,

- Procedures related to two of the elements need clarifying.

4) Implementation of the standard is minimal or there is no evidence of

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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implementation at all; e.g.,

- Behavioral assessments do not address one of the elements.

BSM 2.06

A behavior support and management plan is based on assessment results, identifies proactive interventions to prevent the potential need for crisis interventions, and:

a. identifies strengths-based strategies that will help the person de-escalate their behavior and prevent harassing, violent, or out-of-control behavior;
b. specifies interventions that may or may not be used, taking the individual's trauma history into account;
c. is modified as necessary; and
d. is developed in collaboration with the service recipient and is signed by the person, his/her parent or legal guardian, and personnel, as appropriate.

Related: JJD 2.04, RTX 12.05, FKC 13.05

NA *The organization prohibits the use of restrictive behavior management interventions.*

Note: *The behavior support plan, sometimes called a crisis plan, can be part of, and reviewed with, the overall service or treatment plan.*

Note: *Organizations serving youth involved with the juvenile justice system should refer to the Interpretation in BSM 2.01 regarding the involvement of youths' parents or legal guardians.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- One of the elements needs strengthening; or
- There are a few instances where signatures were missing.

3) Practice requires significant improvement; e.g.,

- Two of the elements need strengthening or one of the elements is not addressed; or
- There is no evidence that the plans, once developed, are rarely reviewed or updated; or
- Most plans are not signed.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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4) Implementation of the standard is minimal or there is no evidence of implementation at all.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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(FOC) BSM 3: Safety Training

Personnel receive behavior support training that promotes a safe and therapeutic service environment, is responsive to individual triggers, and takes a trauma-informed approach.

Related: JJCM 8.01, JJD 12.01, JJR 18.01, FKC 19.06

Note: *Refer to ASE for standards regarding safety in the service environment.*

Rating Indicators

1) The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 3 Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 3 Practice standards.

3) Practice requires significant improvement, as noted in the ratings for the BSM 3 Practice standard; and/or

- One of the BSM 3 Fundamental Practice Standards received a 3 or 4 rating.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 3 Practice standards; and/or

- Two or more of the BSM 3 Fundamental Practice Standards received a 3 or 4 rating.

Table of Evidence

Self-Study Evidence

- Table of contents for personnel BSM training curriculum
- List of personnel required to receive competency based training, and the dates training was received

On-Site Evidence

- Training curriculum for personnel and foster parents that addresses:
  a. Recognizing and responding to behavior management issues
  b. De-escalation
- Training records that document BSM training

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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On-Site Activities

- Interview:
  a. Relevant personnel

(FP) BSM 3.01

All personnel receive initial and ongoing competency-based training, appropriate to their responsibilities, on the organization's behavior support and management intervention policies, procedures, and practices.

Interpretation: *For example, non-direct service personnel should be trained on how to appropriately respond to incidents of out-of-control behavior that they may observe or ways they can help create a more therapeutic environment even they work indirectly with service recipients. This does not mean non-direct service personnel, such as administrative staff, participate in hands on interventions or necessitate that level of training.*

Interpretation: *Organizations that do not permit restrictive interventions should train their personnel on how to respond to behaviors that threaten the safety of service recipients and perssonnel and procedures for the last resort measure in order to maintain a safe and therapeutic environment (e.g., policies and procedures outlining when it is necessary to call the police).*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- The curriculum is not fully developed or lacks depth; or
- A few personnel have not been trained.

3) Practice requires significant improvement; e.g.,

- A significant number of staff have not been trained.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

(FP) BSM 3.02

Personnel receive training that includes:

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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a. practices that promote positive behavior;
b. recognizing challenging behaviors that are a threat to self or others, psychosocial issues, and medical conditions;
c. the impact of the physical environment and other contributing factors that may lead to a crisis;
d. understanding the impact of staff behaviors and responses on the behavior of service recipients; and
e. limitations, including the potential of retraumatization, on the use of restrictive interventions.

Related: BSM 2.01

Interpretation: *Training should also address management of age-appropriate, but potentially dangerous behavior, for example, ways to protect a child who runs into the street so as not to harm him/her.*

Interpretation: *Psychosocial issues should include the role a service recipient's trauma history may play in their challenging behaviors and reactions to crisis interventions.*

Research Note: *Research regarding trauma-informed approaches to address service recipients' challenging behaviors highlights the importance of including trauma in the staff training, specifically looking at the long-lasting effects of trauma on behavior, its prevalence in the relevant service population, and strategies for hope and recovery.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- The curriculum related to one of the elements is not fully developed or lacks depth; or
- A few personnel have not been trained but only work with clients under the oversight of trained personnel.

3) Practice requires significant improvement; e.g.,

- The curriculum related to two of the elements is not fully developed or lacks depth; or
- Training does not address one of the elements at all; or
- A significant number of staff have not been trained.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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(FP) BSM 3.03

Training addresses methods for de-escalating volatile situations, including:

a. listening and communication techniques, such as negotiation, centering strengths, and mediation;
b. involving the person in regaining control and encouraging self-calming behaviors;
c. separation of individuals involved in an altercation;
d. offering a voluntary escort to guide the person to a safe location;
e. voluntary withdrawal from the group or milieu allow the person to calm down; and
f. other non-restrictive ways of de-escalating and reducing episodes of aggressive and out-of-control behavior.

Intepretation: *In regards to element (f), organizations that create individualized behavior plans should include some of the non-restrictive ways of de-escalating identified in those plans as part of their training.*

Research Note: *Literature indicates that when staff are trained and supported in the use of alternate methods in crisis situations, the use of seclusion and restraint is reduced dramatically.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- The curriculum related to one of the elements is not fully developed or lacks depth; or
- A few personnel have not been trained but only work with clients under the oversight of trained personnel.

3) Practice requires significant improvement; e.g.,

- The curriculum related to two of the elements is not fully developed or lacks depth; or
- Training does not address one of the elements at all; or
- A significant number of staff have not been trained.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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(FOC) BSM 4: Restrictive Behavior Management Intervention Training

Personnel who use restrictive behavior management interventions are trained and evaluated on an annual basis.

Related: JJCM 8.01, JJD 12.01

Interpretation: *COA recommends that organizations evaluate training programs and models to select a comprehensive and safe curriculum for use with personnel and service recipients.*

NA *The organization prohibits the use of restrictive behavior management interventions.*

Rating Indicators

1) The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 4 Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 4 Practice standards.

3) Practice requires significant improvement, as noted in the ratings for the BSM 4 Practice standard; and/or

- One of the BSM 4 Fundamental Practice Standards received a 3 or 4 rating.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 4 Practice standards; and/or

- Two or more of the BSM 4 Fundamental Practice Standards received a 3 or 4 rating.

Table of Evidence

Self-Study Evidence

- Table of contents for personnel restrictive behavior management training curriculum
- Training schedules
- Procedures for analyzing the effectiveness of each segment of training

On-Site Evidence

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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- Training curriculum that addresses BSM 4.01
- Documentation of restrictive behavior management training provided

On-Site Activities

- Interview:
  a. Clinical or program directors
  b. Supervisors
  c. Relevant personnel

(FP) BSM 4.01

Personnel designated to use restrictive behavior management interventions receive annual training on permitted interventions, including:

a. proper and safe use of interventions, including when it is appropriate to use a restrictive intervention and time limits for use;
b. understanding the experience of being placed in seclusion or a restraint, including the medical and therapeutic risks related to restrictive interventions and the resulting consequences of the misuse of restrictive interventions, including trauma and retraumatization;
c. response techniques to prevent and reduce injury;
d. evaluating and assessing physical and mental status, including signs of physical distress, vital indicators, and nutritional, hydration, and hygiene needs;
e. readiness to discontinue use of the intervention;
f. when medical or other emergency personnel are needed; and
g. documentation and debriefing.

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- The curriculum related to one of the elements is not fully developed or lacks depth; or
- A few personnel have not been retrained within 12 months but are scheduled to be retrained within 30 days.

3) Practice requires significant improvement; e.g.,

- The curriculum related to two of the elements is not fully developed or lacks depth; or
- More than a few personnel have not been retrained within 15 months but

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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are scheduled to be retrained.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

- The curriculum related to three or more of the elements is not fully developed or lack depth; or
- One of the elements is not covered at all; or
- More than a few personnel have not been retrained within 15 months and there is no schedule for retraining; or
- Personnel consistently do not receive training.

(FP) BSM 4.02

Personnel who receive training on restrictive behavior management interventions receive a post-test and are observed in practice to ensure competency.

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,

- Competency procedures need minor clarification; or
- StaffÂ have been trained but a few did not receive a post-test.

3) Practice requires significant improvement; e.g.,

- A significant number of staff did not receive a post-test; or
- A few were not observed in practice.

4) Implementation of the standard is minimal or there is no evidence of implementation at all;

- StaffÂ do not routinely receive a post-test or are not observed in practice.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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(FOC) BSM 5: Restrictive Behavior Management Interventions

Restrictive behavior management interventions are used in a manner that protects the safety and well-being of service recipients and personnel in crisis situations when less-restrictive measures have proven ineffective.

Related: BSM 2.02

Interpretation: *This standard prohibits the use of seclusion, and manual or mechanical restraint for the purposes of routine discipline, compliance, or convenience.*

The use of mechanical restraints is prohibited for public or private non-medical, community-based facilities that serve children and youth according to the Public Health Service Act, as amended by the Children's Health Act of 2000. As referenced in BSM 1.01, organizations serving youth involved with the juvenile justice system may be subject to different laws and regulations, and should familiarize themselves with any laws and regulations addressing the behavior management interventions they are permitted to employ.

NA *The organization prohibits the use of restrictive behavior management interventions.*

Rating Indicators

1) The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 5 Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 5 Practice standards.

3) Practice requires significant improvement, as noted in the ratings for the BSM 5 Practice standard; and/or

- One of the BSM 5 Fundamental Practice Standards received a 3 or 4 rating.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 5 Practice standards; and/or

- Two or more of the BSM 5 Fundamental Practice Standards received a 3 or 4 rating.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Behavior Support and Management

Table of Evidence

Self-Study Evidence

- Authorization and reauthorization procedures including qualifications of authorized personnel
- Procedures for continuous monitoring during a restrictive intervention

On-Site Evidence

- Incident reports
- Behavior management logs
- Documentation of compliance with legal requirements
- Documentation of continuous monitoring during a restrictive intervention

On-Site Activities

- Interview:
  a. Authorizing personnel
  b. Direct service personnel
  c. Supervisory personnel
  d. Persons served
- Seclusion room observation

BSM 5.01

Qualified personnel authorize each restrictive behavior management intervention, in accordance with any applicable federal or state requirements.

Related: BSM 5.07

Interpretation: *Personnel are qualified through annual training and evaluation.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Authorization procedures need clarifying.

3) Practice requires significant improvement; e.g.,

- There have been instances of restrictive intervention without

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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authorization by qualified personnel but corrective action is occurring; or
- Documentation is weak.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- There have been instances of restrictive intervention without authorization by qualified personnel and corrective action has not been initiated; or
- Practices are in violation of applicable legal requirements; or
- Written procedures do not address use of qualified personnel.

(FP) BSM 5.02

Service recipients are monitored continuously, face-to-face, and assessed at least every 15 minutes for any harmful health or psychological reactions.

Note: *Refer to BSM 5.06 for the maximum time allowed for a restrictive intervention.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- In a few rare instances there was a lapse in monitoring or assessment but corrective action was taken immediately.

3) Practice requires significant improvement; e.g.,

- In more than a few instances there was a lapse in monitoring or assessment but corrective action was taken immediately; or
- Documentation is weak; or
- Procedures need significant strengthening.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

- Lapses occur with some frequency and corrective action is not taken; or
- There are no procedures; or
- Procedures are not routinely followed.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

(FP) BSM 5.03

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Procedures address safe methods for involuntarily escorting individuals.

Interpretation: *This includes methods such as the backwards escort.*

NA *The organization does not escort individuals or use seclusion.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Procedures need clarifying.

3) Practice requires significant improvement; e.g.,

- Procedures are inadequate; or
- There have been instances where procedures were not followed; or
- Documentation is weak.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- There are no procedures; or
- Procedures are not routinely followed.

(FP) BSM 5.04

Seclusion rooms conform to existing licensing and/or fire safety requirements and are limited to one person at a time.

Interpretation: *Seclusion rooms need to be outfitted with a door that easily opens in case of emergency, such as a spring lock door.*

NA *The organization does not use locked seclusion.*

Note: *Please see Facility Observation Checklist - Private, Public, Canadian for additional assistance with this standard.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- The organization does not have evidence of conformance to licensing and/or fire safety requirements for one of its isolation or seclusion rooms, but has initiated a process to obtain it.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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3) Practice requires significant improvement; e.g.,

- The organization does not have evidence of conformance with licensing and/or fire safety requirements for one or more of its isolation or seclusion rooms and has not initiated a process to obtain it; or
- There have been instances where a seclusion or isolation room has been used for more than one person.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

(FP) BSM 5.05

During a restrictive behavior management intervention staff assess the service recipient's need for food, water, and use of bathroom facilities and provide access when safe and appropriate.

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Procedures need clarifying.

3) Practice requires significant improvement; e.g.,

- Procedures are inadequate; or
- There have been instances where procedures were not followed, but corrective action has been initiated; or
- Documentation needs significant strengthening.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- There are no procedures; or
- Procedures are not routinely followed.

(FP) BSM 5.06

Restrictive behavior management interventions are used only in crisis situations, when less-restrictive measures have proven ineffective, are discontinued as soon as possible, and are limited to the following maximum time periods per episode:

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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a. 15 minutes for children aged nine and younger, for all restrictive behavior management interventions;
b. 30 minutes for individuals aged ten and older, undergoing manual or mechanical restraint;
c. 30 minutes for individuals aged ten to thirteen in seclusion; and
d. one hour for individuals aged fourteen and older in seclusion.

Interpretation: *If the state law is more stringent in the maximimum time periods per episode, then the organization must follow the time frames set by the state law.*

Interpretation: *Restrictive behavior management interventions are discontinued immediately if they produce adverse side effects such as illness, severe emotional or physical stress, or physical injury. Timeframes may be extended on a case-by-case basis, but qualified personnel with the authority to make such decisions must approve all extensions, as referenced in BSM 5.07.*

Interpretation: *As referenced in BSM 1.02, organizations serving youth involved with the juvenile justice system may be authorized to use restrictive interventions to prevent escapes or protect property, but should only do so when absolutely necessary, as referenced throughout these standards.*

Further, although organizations serving youth involved with the juvenile justice system may be authorized to use time limits that exceed those listed in the standard, COA expects these organizations to meet the timeframes outlined in the standard whenever possible. When it is necessary to extend timeframes in order to maintain safety, security, and order (for example, when youth must be transported in mechanical restraints in order to prevent escape, and travel time is greater than 30 minutes), qualified personnel must approve the extension, and the intervention should be discontinued as soon as possible.

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Procedures need clarifying.

3) Practice requires significant improvement; e.g.,

- Procedures are inadequate; or
- There have been instances where procedures were not followed, but corrective action has been initiated; or

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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- Documentation needs significant strengthening.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- There are no procedures; or
- Procedures are not routinely followed.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

(FP) BSM 5.07

Reauthorization by qualified personnel is required for each instance of isolation, locked seclusion, manual restraint, or mechanical restraint that exceeds the maximum time limit.

Related: BSM 5.01

Intepretation: *Indivudals are qualified to reauthorize a restrictive intervention through training and evaluation and in accordance with any applicable federal or state requirements.*

Note: *See maximum time limits outlined in BSM 5.06.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Procedures need clarifying.

3) Practice requires significant improvement; e.g.,

- Procedures are inadequate; or
- There have been instances where procedures were not followed, but corrective action has been initiated; or
- Documentation needs significant strengthening.

4) Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- There are no procedures; or
- Procedures are not routinely followed.

BSM 5.08

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Behavior Support and Management

The organization has procedures to address the safe removal of individuals in seclusion or mechanical restraint in the event of an emergency evacuation.

Related: ASE 7.01

NA *The organization uses manual restraint only.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g., Â

- Procedures need clarifying.

3) Practice requires significant improvement; e.g.,Â

- Procedures are inadequate; or
- There have been instances where procedures were not followed, but corrective action has been initiated; or
- Documentation needs significant strengthening.

4) Practice requires significant improvement; e.g.,Â

- Procedures are inadequate; or
- There have been instances where procedures were not followed, but corrective action has been initiated; or
- Documentation needs significant strengthening.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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(FOC) BSM 6: Documentation and Debriefing

The organization assesses restrictive behavior management incidents and effects to reduce future preventable occurrences and untoward consequences.

NA *The organization prohibits the use of restrictive behavior management interventions.*

Rating Indicators

1) The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 6 Practice standards.

2) Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 6 Practice standards.

3) Practice requires significant improvement, as noted in the ratings for the BSM 6 Practice standard; and/or

- One of the BSM 6 Fundamental Practice Standards received a 3 or 4 rating.

4) Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 6 Practice standards; and/or

- Two or more of the BSM 6 Fundamental Practice Standards received a 3 or 4 rating.

Table of Evidence

Self-Study Evidence

- Debriefing procedures

On-Site Evidence

- Documentation of debriefing
- Documentation of Behavior management/incident reviews
- Behavior management logs

On-Site Activities

- Interview:
  a. Governing body
  b. Supervisory/management personnel

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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c. Persons served
d. Parents/legal guardians

- Case Record Review

BSM 6.01

The use of restrictive behavior management interventions is documented, including:

a. the justification, use, circumstances, and length of application in the individual's case record;
b. all attempts made prior ro the use of a restrictive behavior management intervention in order to preempt it, including the strategies identified in the individual's behavior management plan; and
c. names of the service recipient and personnel involved, reasons for the intervention, length of intervention, and verification of continuous visual observation in a log.

Research Note: *For organizations using Root Cause Analyses, documentation could include the "5 Whys" of the incident (asking why an incident happened and then asking why 4 more times) and can be helpful in understanding the reasons why a restrictive intervention was necessitated thus allowing for a more in-depth analysis of all contributing factors and identifying changes needed.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- Procedures need clarifying; or
- In a few instances documentation was not complete.

3) Practice requires significant improvement; e.g.,

- Procedures are inadequate; or
- Documentation problems are common but corrective action is being taken.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

(FP) BSM 6.02

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Behavior Support and Management

Debriefing occurs in a safe, confidential setting within 24 hours of the incident and includes the service recipient, appropriate personnel, and parents or legal guardian, when possible, to:

a. evaluate physical and emotional well-being;
b. identify the need for counseling, medical care, or other services related to the incident;
c. identify antecedent behaviors and modify the service plan as appropriate; and
d. facilitate the person's reentry into routine activities.

Interpretation: *When organizations serving youth in the juvenile justice system use mechanical restraints to prevent escape during transport, rather than in response to an incident, it may not be relevant to identify antecedent behaviors and modify the service plan, as referenced in element (c) of the standard. However, elements (a), (b), and (d) are still relevant.*

Interpretation: *The organization ensures the service recipient's participation in the debriefing process. In situations where the service recipient initially refuses to participate, the organization should make continued attempts to involve the individual.*

Interpretation: *If the parent or legal guardian is unable to be reached within the 24 hour period, all attempts to reach them should be document and there should be continued outreach attempts past the 24 hour period to notify them of the incident.*

Interpretation: *Appropriate personnel includes frontline and clinical staff so that both perspectives are represented in any modifications made to the service plan.*

Research Note: *Structured debriefing, with a standard set of questions, can be beneficial in gathering data on restrictive behavior management incidents for future review.*

Note: *Organizations serving youth involved with the juvenile justice system should refer to the Interpretation to BSM 2.01 regarding the involvement of youths' parents or legal guardians.*

Note: *Following each incident of restrictive intervention, Medicaid requires that a physician or other qualified clinician conducts and documents an initial face-to-face assessment and summary review within one hour of the intervention to evaluate the health and safety of client, the appropriateness of the intervention, and necessary changes to the treatment plan.*

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Behavior Support and Management

Organizations should review state Medicaid plans for their state's definition of a qualified clinician and a list of specific elements to be included as part of the assessment.

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- One of the elements is not regularly addressed; or
- In a few instances:
  - Debriefing occurred after 24 hours; or
  - One of the required attendees was absent.

3) Practice requires significant improvement; e.g.,

- Two of the elements are not regularly addressed; or
- In several instances:
  - Debriefing occurred after 24 hours; or
  - One or two of the required attendees was absent.

4) Implementation of the standard is minimal or there is no evidence of implementation at all;

- One of the elements is not addressed at all; or
- Timeframes are routinely exceeded; or
- One of the required attendees is routinely excluded.

(FP) BSM 6.03

Personnel involved in the incident are debriefed to assess:

a. their current physical and emotional status;
b. the precipitating events; and
c. how the incident was handled and necessary changes to procedures and/or training to avoid future incidents

Interpretation: *When organizations serving youth in the juvenile justice system routinely use mechanical restraints to prevent escape during transport, rather than in response to an incident, it may not be relevant to assess precipitating events or address how future incidents might be avoided, as referenced in elements (b) and (c) of the standard.*

Rating Indicators

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- In a few instances one of the elements was not addressed.

3) Practice requires significant improvement; e.g.,

- In several instances one of the elements was not addressed; or
- In a few instances staff were not debriefed.

4) Implementation of the standard is minimal or there is no evidence of implementation at all;

- One of the elements is not addressed at all; or
- Staff are frequently not debriefed.

(FP) BSM 6.04

Any other person involved in or witness to the incident is debriefed to identify possible injuries and emotional reactions.

Interpretation: *Debriefing can include a discussion of factors that led up to the incident and other appropriate responses for future situations. Emphasis should be placed on returning the environment to pre-incident condition and resuming the normal program routine.*

Rating Indicators

1) The organization's practices reflect full implementation of the standard.

2) Practices are basically sound but there is room for improvement; e.g.,Â

- In a few instances the debriefing did not occur.

3) Practice requires significant improvement; e.g.,

- In several instances debriefing did not occur.

4) Implementation of the standard is minimal or there is no evidence of implementation at all.

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and staff.

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Attachment B

Forms for reporting use of seclusion or restraint

PROGRESSIVE BEHAVIORAL INTERVENTION RECORD Name ______________________ Hosp # ________

Date | **Intervention Started:** ☐ **A** ☐ **B** ☐ **On Grounds (not A/B)** ☐ **Off Grounds**

Signatures Leader: **Staff:**

For less restrictive interventions used prior to R, circle all that apply: 1:1 Verbal Intervention Redirection Time in Own Room or TOR Chair Provided a distraction or alternative Offered a PRN Comfort Rooms Chill Out Plan Corrective Teaching

Intervention occurred due to imminent danger as evidenced by
☐ **Severe Aggression** ☐ **Elopement** ☐ **Significant Self-Harm** ☐ **Perilous Property Damage**

Code M – PRN med R = Restraint	Time	Initial	Description of Initial & Ongoing Behavior/Interventions Attempted
Out Time			**Behavior at end of intervention**

Nurse and Physician – page 2

RESTRAINT ASSESSMENT & ORDER Name _____ Hosp # _____

Name of MD & Time Notified _____ **RN Initial** _____ **Time Renotify** _____

MD ORDER	☐ **Initiate Bridge Building Restraint techniques:** ☐ Come-Along ☐ Littles ☐ Wall Stabilization ☐ Corner Stabilization ☐ Floor Stabilization ☐ 2-person ☐ 3-person ☐ Other (describe) _____	**RN Signature**	☐ TO ☐ VO ☐ RBV	**Date Time**	
Time Limit	☐ **up to 1 hr (age 8 or younger)** ☐ **up to 2 hrs (age 9 or older)**	**MD Signature**		**Date Time**	

Criteria to End Intervention (as explained to child) _____

_____

_____

RN 15 MINUTE CHECKS – enter time 1	2	3	4	5	6	7	*Column 1 is required initial assessment by RN*	
							←Times ↙ Initials	Comments
							Injury/Medical Issue	
							Nutrition/Hydration	
							Circul/Range of Motion, Vital Signs	
							Hygiene/Restroom	
							Physical/Psychol Status, Comfort	
							Readiness for Release	

MD Follow-up Comments **Time** _____ **Signature** _____

CHILD'S DEBRIEFING Staff Initials _____ Date _____ Time _____

What upset you most? _____

Did we do anything that got in the way of you calming down? _____

_____

Did we do anything that was especially helpful to you? _____

_____

What can we do better next time? _____

Do you have any concerns about the restraint? ☐ yes ☐ no _____

_____

Did you feel pain? ☐ yes ☐ no ▪ If yes, where? _____

Nurse follow up of pain complaint _____ Date/time _____ Nurse Signature

_____

_____

Nurse Notification of family/guardian (if applicable) _____ Date/time _____ Nurse Signature

✱ ***REMEMBER*** *– If restraint is necessary beyond the time-limited order, a <u>second</u> order must be obtained from MD and a new form begun.*

Staff Debriefing Form

Evansville Psychiatric Children's Center

Name _____ Hosp # _____

Date/Time of Incident	Date/Time of Debriefing	Reviewed By
Past Trauma Experience	☐ Physical abuse ☐ Sexual abuse ☐ Emotional abuse ☐ Physical neglect ☐ Emotional neglect ☐ Drug addicted/alcoholic family member ☐ Incarceration of a family member ☐ Witness of domestic violence ☐ Mentally ill, depressed, or suicidal family member ☐ Loss of a parent to death or abandonment	
Attitudes ☐ We are here for the student ☐ We are guests in their home ☐ Communicating "I am with you" ☐ I can handle this calmly Staff Used ☐ There is no enemy out there ☐ Gentle touch is calming ☐ Strength sets up resistance ☐ Agitation/Aggression are stress reactions		
Triggers/Unmet need		

In terms of 5-level Model, what behaviors did the patient demonstrate at the different levels, and what interventions did staff make?

LEVEL	PATIENT BEHAVIOR	INTERVENTION
Anxiety	What signs were seen—tension, restlessness, irritability, sense of uneasiness?	Was child encouraged to ventilate; positive support provided?
Anger	Was child needing attention and immediate action, increased demands, using "shoulds," cursing, using loud voice?	Was child provided alternatives/suggestions, choices, opportunity to make right decision?
Hostility	Did anger expression become more personalized, threats, intimidation?	Were clear directives given, limits set, consequences noted?
Aggression	Did child strike out physically or start destroying things?	Which Bridge Building non-offensive control techniques were implemented and used properly?

Comments, Questions or Concerns

Staff at Incident	*Leader*	*Others*

Check if Occurred		DATE:
	1.	Formal debriefing held within 48 hours or next business day (if weekend/holiday).
	2.	Led by credentialed facilitator not involved in event.
	3.	Did the stage of escalation match staff response?
	4.	What was the trigger/antecedent? _____
	5.	Timely response demonstrated.
	6.	Chill out Plan offered
	7.	How was Imminent danger threshold identified?
	8.	What was reason for restraint? _____
	9.	Reason for wall, corner, floor stabilization_____
	10.	ASAP release.
	11.	Immediate post debriefing activities carried out.
	12.	Learning occurred and is documented.
	13.	Follow-up recommendations made.
Check if Debriefing Included		Attendance Signature
	1.	Administration representative
	2.	Attending physician/NP
	3.	RN
	4.	Therapist
	5.	OT
	6.	RT
	7.	Other

_____ | _____

_____ | _____

_____ | _____

_____ | _____

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Remarkable people. Remarkable results.

DATE
October 1, 2018

Emergency Safety Intervention Report

PATIENT NAME	TEST, TEST	**MR#**	1902306
DATE OF BIRTH	**GENDER:**M	**MARITAL STATUS**	N
ADMISSION DATE		**SERVICE DATE**	10/01/2018

PENDING NOTE

Client Name:
TEST, TEST

Client Code:
1902306 - 01

Time Initiated:

Time Ended:

Duration:

Unit/Program and License Number:

DAMAR FREEWAY ACADEMY

Incident Type: "Aggression - Client to staff

Incident Number: 435105945275369

Type of Intervention:

- Small Child Restraint
- Small Child Restraint Against Wall
- Standing Restraint
- Seated Restraint
- Supine Restraint
- Other

Clinical Justification for Intervention:

- Danger to Self
- Danger to Others
- Behavior Support Plan

DiagCode1	DiagCode2	DiagCode3	DiagCode4	DiagCode5	DiagCode6	DiagCode7

Staff Involved in Crisis:

Test.

Staff Involved in Intervention:

What "triggered" the behavior? Be specific (i.e. bad visit, bad phone call, arguement with peers, etc.)

What behaviors are the client showing that is dangerous to self or others? Be specific

What types of interventions were used to prevent the use of the Emergency Safety Intervention?

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DATE	Emergency Safety Intervention Report	Page #
October 1, 2018		2

PATIENT NAME	TEST, TEST	**MR#**	1902306
DATE OF BIRTH	**GENDER:**M	**MARITAL STATUS**	N
ADMISSION DATE		**SERVICE DATE**	10/01/2018

PENDING NOTE

Removal From Situation	1:1 Talk with Staff	Write/Color/Draw
Caring Gesture	Comfort Room	Deep Breathing
Count to 10	Managed Environment	Time Away
Ideation	Alternate Activity	Go for Walk
Other		

Other:

What criteria did client have to meet in order to be let out of the hold? (CHECK ALL THAT APPLY.)

Comply With Staff Direction	Improved Mood	No Verbalization of Harm to Self
No Swearing	No Verbalization to Harm Others	Identify One Feeling
Relaxed Body	Talking in a Normal Tone	Other

Other

Directives/Clinical On Call Review

Client may be placed in a:

Small Child Restraint | Small Child Restraint Against Wall | Standing Restraint | Seated Restraint
Supine Restraint | Removal | Seclusion for no greater than | due to

Initial Review Obtained From: Time:

Initial Review Received By: Time:

Continuation Directive Instructions:

Continuation Directive Obtained From: Time:

Continuation Direction Received By: Time:

Clinical On Call Signature

15 Minute Assessment (0-15 Minutes)

Behavior During the Emergency Safety Intervention (Check all that apply)

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Emergency Safety Intervention Report

PATIENT NAME	TEST, TEST	**MR#**	1902306
DATE OF BIRTH	**GENDER:**M	**MARITAL STATUS**	N
ADMISSION DATE		**SERVICE DATE**	10/01/2018

PENDING NOTE

Yelling/Screaming	Spitting	Head banging
Self-inflicted Injurious Behavior	Crying	Biting
Talking	Singing	Kicking
Mumbling	Profanities	Hitting
Pinching	Threatening	Scratching
Combative	Other	

Other:

Movement:

Normal	Reports Pain	Lethargic	Restricted

Other:

Skin Color:

Normal	Pale	Other

Other:

Respiration:

Normal	Rapid	Pressured	Other

Other:

Any request made in regard to personal needs?

If yes, explain:

*If injury has been identified, complete emergency safety intervention with injury debriefing.

Resource/Nurse Signature _____ Time:

30 Minute Assessment (16-30 Minutes)

Behavior During the Emergency Safety Intervention (Check all that apply)

Yelling/Screaming	Spitting	Head banging
Self-inflicted Injurious Behavior	Crying	Biting
Talking	Singing	Kicking
Mumbling	Profanities	Hitting
Pinching	Threatening	Scratching
Combative	Other	

Other:

Movement:

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PATIENT NAME	TEST, TEST	**MR#**	1902306
DATE OF BIRTH	**GENDER:**M	**MARITAL STATUS**	N
ADMISSION DATE		**SERVICE DATE**	10/01/2018

PENDING NOTE

Normal	Reports Pain	Lethargic	Restricted

Other:

Skin Color:

Normal	Pale	Other

Other:

Respiration:

Normal	Rapid	Pressured	Other

Other:

Any request made in regard to personal needs?

If Yes, Explain:

*If injury has been identified, complete emergency safety intervention with injury debriefing.

Time:

Resource/Nurse Signature

Must receive clinical on call directive to continue restraint beyond 30 minutes!!! 45 Minute Assessment (31-45 Minutes)

Behavior During the Emergency Safety Intervention (Check all that apply)

Yelling/Screaming	Spitting	Head banging
Self-inflicted Injurious Behavior	Crying	Biting
Talking	Singing	Kicking
Mumbling	Profanities	Hitting
Pinching	Threatening	Scratching
Combative	Other	

Other:

Movement:

Normal	Reports Pain	Lethargic	Restricted

Other:

Skin Color:

Normal	Pale	Other

Other:

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PENDING NOTE

Respiration:

Normal	Rapid	Pressured	Other

Other:

Any request made in regard to personal needs?

If Yes, Explain:

*If injury has been identified, complete emergency safety intervention with injury debriefing.

Resource/Nurse Signature Time:

60 Minutes Assessment (45-60 Minutes)

Behavior During the Emergency Safety Intervention (Check all that apply)

Yelling/Screaming	Spitting	Head banging
Self-inflicted Injurious Behavior	Crying	Biting
Talking	Singing	Kicking
Mumbling	Profanities	Hitting
Pinching	Threatening	Scratching
Combative	Other	

Other:

Movement:

Normal	Reports Pain	Lethargic	Restricted

Other:

Skin Color:

Normal	Pale	Other

Other:

Respiration:

Normal	Rapid	Pressured	Other

Other:

Any request made in regard to personal needs?

If Yes, Explain:

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Emergency Safety Intervention Report

PATIENT NAME	TEST, TEST	**MR#**	1902306
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PENDING NOTE

*If injury has been identified, complete emergency safety intervention with injury debriefing.

Time:

Resource/Nurse Signature

Behavior After Intervention

Behavior Displayed After Hold (Check all that apply.)

Calm	Uncooperative	Withdraw
Cooperative	Returned to Millieu	Comply With Staff
Crying	Improved Mood	Quiet
Aggressive	Defensive	Agitated
Relaxed Body	Other	

Other:

Nurse Signature

Time:

Post Emergency Safety Intervention Assessment

Physical Assessment

Physical Status

- No Pain
- Musculoskeletal System Intact
- ABC's Fully Intact
- Range of Motion to all Extremities

Complaint of injury/side effect from ESI?

If yes, did the ESI with Injuring debriefing occur?

Medical follow-up needed?

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DATE
October 1, 2018

Emergency Safety Intervention Report

PATIENT NAME	TEST, TEST	**MR#**	1902306
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PENDING NOTE

Physical notified?

If yes, describe:

Time:

Nurse Signature

Emotional Assessment

Psychological Status:

- Stable
- Oriented
- Verbally Contracting for Safety
- Demonstrates Ability to Maintain Safety

Mood/Affect:

- Angry
- Flat
- Animated
- Calm
- Tearful
- Sad
- Blunted
- Labile
- Bright

Thought Process:

- Goal-directed
- Circumstantial
- Tangential
- Loose Associations
- Flight of Ideas

Hallucinations:

- Denies
- Visual
- Auitory
- Tactile

Intervention Resulted In:

- Potential Injury to Self or Others was Avoided
- Client Demonstrates Self Control

Speech/Language:

- Normal
- Pressured
- Rapid
- Stuttering
- Non-responsive

Complication Arising From Intervention:

Nurse Signature

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Emergency Safety Intervention Report

PATIENT NAME	TEST, TEST		**MR#**	1902306
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ADMISSION DATE			**SERVICE DATE**	10/01/2018

PENDING NOTE

Time:

Notification

Parent/Legal Guardian Notified of ESI? Time: Date: 02/14/2019

Explain:

If no, was there an alternative method of notification?

If yes, explain:

Parent/Legal Guardian Name: Agency Rep Making Contact:

Placing Agency Notified of ESI? Time: Date: 02/14/2019

Explain:

If no, was there an alternative method of notification?

If yes, explain:

Placing Agency Contact Name: Agency Rep Making Contact:

Other Contacts Made:

CPS/APS	02/14/2019	Time:
IPAS	02/14/2019	Time:
Medicaid	02/14/2019	Time:
Central Licensing	02/14/2019	Time:
Other:	02/14/2019	Time:

Signature

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PATIENT NAME	TEST, TEST	**MR#**	1902306
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ADMISSION DATE		**SERVICE DATE**	10/01/2018

PENDING NOTE

Behavioral Support Debriefing (To be completed by end of shift of ESI.)

Client:

Nurse:

Supervisor:

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DATE	Emergency Safety Intervention Report	Page #
October 1, 2018		10

PATIENT NAME	TEST, TEST		**MR#**	1902306
DATE OF BIRTH		**GENDER:**M	**MARITAL STATUS**	N
ADMISSION DATE			**SERVICE DATE**	10/01/2018

PENDING NOTE

Staff:

Staff:

Staff:

Staff:

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PATIENT NAME	TEST, TEST		**MR#**	1902306
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PENDING NOTE

LSI Used:

I-E-S-C-A-P-E
I-P-E
Other (BSP approved)

"Explore" - Describe the clients account of what happened in his/her own words:

"Connect the Feelings to the Behavior" - Describe how s/he feelings may have triggered the behavior:

"Alternative Behaviors/Planned Behaviors in the Future" - Describe the client identified actions/behaviors that could have been done differently:

Following the ESI, the client identified feeling:

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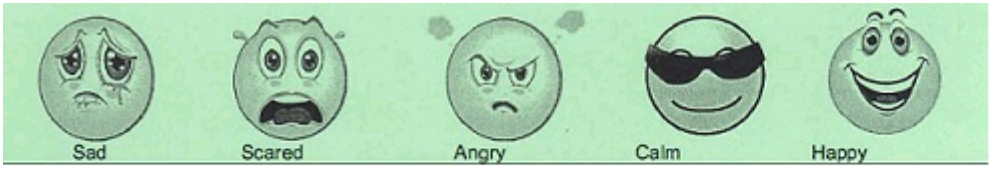
PATIENT NAME	TEST, TEST	**MR#**	1902306
DATE OF BIRTH	**GENDER:**M	**MARITAL STATUS**	N
ADMISSION DATE		**SERVICE DATE**	10/01/2018

PENDING NOTE



Clients right to privacy, dignity and well - being addressed?

Staff processed with client any trauma that may have resulted from the ESI?

Staff Debriefing (To be completed within 24 hours of ESI.)

Nurse:

Supervisor:

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DATE	Emergency Safety Intervention Report	Page #
October 1, 2018		13

PATIENT NAME	TEST, TEST		**MR#**	1902306
DATE OF BIRTH		**GENDER:**M	**MARITAL STATUS**	N
ADMISSION DATE			**SERVICE DATE**	10/01/2018

PENDING NOTE

Staff:

Staff:

Staff:

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PENDING NOTE

Staff:

Describe any staff or client injuries as a result of ESI:

Events that led up to the ESI and precipitating factors:

Alternative techniques that might have prevented the incident:

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Emergency Safety Intervention Report

PATIENT NAME	TEST, TEST		**MR#**	1902306
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PENDING NOTE

Any procedures available to prevent recurrence:

The outcome of the interventions:

Any changes or recommendations to the treatment plan because of ESI:

Attachment C

Model data tracking tool

	SECLUSION AND RESTRAINT EVENT D					
	A. Service Recipients		B. Seclusion			C. Restrai
	Number	Inpatient Hours	Incidents	Hours	Clients	Incidents
All service recipients in facility						
SERVICE RECIPIENT DEMOGRAPHIC CHARACTERISTICS						
Gender						
Male						
Female						
Age						
Children (4-12 years)						
Adolescents (13-17 years)						
Young Adults (18-20 years)						
Adults (21-64 years)						
Elderly (65 years and up)						
Race/Ethnicity						
American Indian / Alaskan Native						
Asian						
Black or African-American						
Hispanic						
Native Hawaiian / Pacific Islander						
White						
Other						
SERVICE RECIPIENT REFERRAL SOURCE						
UNITS WITHIN FACILITY (add lines for additional units if necessary						
A *1*						
B *2*						

ATA (SRED) MATRIX

nt (duration < 5 min)		D. Restraint (duration ≥ 5 min)			E. STAT IM Medication		F. Injury		G. Death
Hours	Clients	Incidents	Hours	Clients	Incidents	Clients	Clients	Staff	Clients