VANDERHEYDEN, INC.
Policy and Procedure

	Effective Date: 11.9.2010	**Last revision 8/28/23**	**Page 1 of 27**	**Policy Number: Volume II A.4.e**
	Board Approval Date: 11.9.2010	**Title: Use of Physical Restraint Policy (OCFS and SED) (Formerly Physical Interventions)**		

I. BACKGROUND

Vanderheyden is committed to a principal of nonviolence, and recognizes experiencing physical, psychological, social and/or moral violence can cause or exacerbate trauma. Employees and volunteers strive to create and maintain a therapeutic milieu by providing a structured and nurturing environment that reduces risk of violence.

Vanderheyden employs a variety of tools to prevent and minimize violence within its programs including maintaining comfortable and safe physical settings and providing quality care to individuals receiving services. All individuals who receive services and all employees are provided regular training on components of an 'Emotional Toolkit." These tools contribute to emotional health and facilitate appropriate reaction to adversity. Tools include: maintaining a written Safety Plan on their person or in their living environment for easy reference in stressful situations; participating in frequent community meetings to check in on feelings and goals; and encouraging engagement in proactive self-care activities.

Vanderheyden recognizes that use of physical restraint can lead to negative outcomes including risk of serious injury or death for the youth and staff involved; emotional harm and trauma to youth and staff; and disruption to the relationships among individuals, their peers, and employees. All individuals receiving services work with their assigned clinician to develop a Behavior Support Plan, which describes individual-specific proactive, non-physical interventions and de-escalation techniques to be used in crisis prior to relying on physical restraint. It also describes the situations in which staff can and cannot use physical restraint.

The objectives of this policy are the following:

- Encourage staff to build strong relationships with youth
- Minimize the use of physical restraints
- Eliminate the use of restraint outside of policy parameters
- Minimize the risk of serious injury or death from the use of physical interventions
- Reduce injuries and further trauma to youth and staff from the use of physical restraint

II. POLICY

Vanderheyden employees will create and maintain appropriate and supportive relationships with the youth in their care in order to reduce the likelihood that problems, conflicts, or behaviors will escalate to a level that requires physical intervention. They will address maladaptive behaviors and crises in a proactive, non-physical manner by

utilizing a continuum of interventions and strategies, including those noted in the youth's behavior support plan.

The use of physical restraint will be authorized in only truly dangerous situations to contain acute physical behavior, which clearly indicates the intent to inflict physical injury upon oneself or others, or otherwise jeopardizes the safety of any person. [18 NYCRR 441.17 (a)]

After attempting to use non-physical means to assist youth in managing their behavior and affect, trained and qualified employees are authorized to use the least amount of force necessary to maintain the safety of staff and youth; that poses the minimum risk of injury to the youth; and that will be only employed for a minimum amount of time necessary before it stabilizes the situation.

The use of excessive or unauthorized force is strictly forbidden. Employees found to have violated the following prohibitions may be subject to penalties including criminal charges, placement on the Staff Exclusion List, and/or disciplinary/corrective action up to and including termination.

All Vanderheyden employees are mandated by law to report staff-on-youth abuse, maltreatment, or any other harmful practices including use of excessive force to the appropriate authority, should they observe or become aware of such behavior.

Vanderheyden prohibits the following:

- Seclusion and all types of isolation including room isolation
- Pharmacological or mechanical restraint
- Excessive or inappropriate use of behavioral interventions, including physical restraint
- The application of behavior management interventions, including physical restraint, by an individual served or any other person other than trained, qualified staff
- Aversive conditioning
- Interventions that involve withholding nutrition or hydration or which inflict physical or psychological pain, fear or harm
- Forced physical exercise to eliminate behaviors
- Forced and/or punitive work assignments
- Group punishment or discipline for individual behaviors
- Use of physical restraint in response to property damage that does not involve imminent danger to self or others.
- Use of physical restraint as punishment, or for the convenience of staff

- Use of physical restraint to enforce compliance with rules or directives
- Use of physical restraint to compel a youth to receive or refuse medication
- Use of prone or face-down restraints

III. DEFINITIONS

A. Acute Physical Behavior - Behavior imminently likely to result in physical injury or harm to oneself or others.

B. Asphyxia -The deprivation of oxygen to living cells. **Positional Asphyxia** is fatal respiratory arrest where breathing is compromised by the positioning of the body in relationship to its immediate surroundings.

C. Behavior Support Plan (BSP) - A documented plan for the use of preferred de-escalation strategies and interventions that tailor to a youth's individual needs and is developed by the youth with his/her treatment team. BSPs include information about the youth's history including common triggers, preferences, successful and unsuccessful strategies, and limitations on physical restraint techniques authorized for the youth. They are designed to help staff recognize the youth's earliest indications of distress and agitation to prevent crisis from evolving.

D. Debriefing - A formal process employed with youth and staff after the use of physical restraint, designed to assess the well-being of youth and team members, and to analyze the effectiveness of the interventions utilized in the youth's Behavior Support Plan, including de-escalation techniques and physical restraint. Debriefing occurs at multiple levels and includes the youth, staff, and administration.

E. Excessive Force – Use of more force than necessary to stabilize the youth and/or situation, or holding a youth in a physical restraint for more time than is necessary to stabilize the youth or situation.

F. Injury - Any physical damage to a person, including, but not limited to, scratches, abrasions, swelling, burns, fractures, results of toxic ingestion or toxic exposure, or internal damage regardless of cause and regardless of the extent or severity, as well as any complaint of such damage or pain by a youth. **Serious Injury** will include any of the following injuries:

- Dislocation
- Lacerations requiring stitches, sealants or other procedures to close
- Concussion
- Fractured or broken bones
- Torn ligaments, muscles or tendons
- Internal injuries

- Damage, breakage, or loss of a tooth/teeth
- Punctured eardrum
- Any hearing loss
- Any loss of vision
- Any loss of consciousness
- Burns
- Any injury to the face, head or neck area
- Poisoning
- Toxic exposure
- Any other injury requiring treatment at a hospital or medical provider.

G. Intervention - Verbal and physical de-escalation skills utilized prior to and throughout the course of a physical restraint

H. Mental Health Crisis - An acute disturbance of thinking, mood, behavior, or social relationships that requires an immediate intervention. Indicators of such a disturbance may include, but are not limited to: suicidal threats, gestures or attempts; self-injurious or self-mutilating behavior; and behavioral or emotional manifestations of psychiatric disorders.

I. Physical Restraint - The use of staff members to partially or fully to immobilize an individual in order to contain acute physical behavior.

J. Seclusion - The practice of involuntarily separating a person from others into a space the person is physically prevented from leaving. **Seclusion is a form of abuse and is prohibited at all Vanderheyden programs.**

K. Staff Exclusion List (SEL)- A list generated and maintained by the New York Justice Center for Protection of People with Special Needs (Justice Center) which contains names of those who have committed serious or repeated acts of abuse or neglect against people with special needs in programs under the Justice Center's jurisdiction. These individuals are barred indefinitely from working in positions requiring regular and substantial contact with people receiving services in New York State.

L. Time Away – An unlocked and supervised area for an individual to voluntarily and safely de-escalate, regain control, and prepare to meet expectations to return to program.

M. Treatment Team- Interdisciplinary group of agency personnel including clinicians, school staff, residential staff, and others who oversee care of each individual, including the efficacy of the Behavior Support Plan.

N. Self-Protection Skills – TCI-approved protective technique that provides team members the ability to protect themselves from a physical attack by a youth.

O. Stabilized – For the purposes of this policy, a youth's behavior has stabilized when their behavior(s) no longer pose a danger to the safety of the youth or others.

P. TCI (Therapeutic Crisis Intervention)- Evidence-based crisis response curriculum developed by Cornell University adopted for use by Vanderheyden in its youth programs including its school, Residential Treatment Center, and OCFS-licensed group homes

Q. Unauthorized Intervention – Any physical technique not trained as part of a team member's TCI certification or authorized by this policy

R. Unauthorized Restraint – Use of physical restraint under circumstances or for reasons not specified by this policy.

S. Use of Force - Any physical contact initiated by team members' that intentionally restricts the movement of a youth. This includes self-protection skills, protective holds, escorts, standing restraint, and prone/supine restraint.

IV. PROCEDURES FOR OCFS LICENSED PROGRAMS

A. Proactive Supervision of Youth

1. Staff are expected to build positive, supportive relationships with youth in their care through proactive, non-physical supervision. *(See Employee Interactions With Individuals Served Policy, Professional Boundaries Policy, Procedures for Supervision of Individuals Served, and Student Supervision Procedures for more information)* DSPs receive training on using positioning (environmental awareness), restructuring, and other proactive supervision practices and techniques, during initial TCI certification and semi-annual refreshers.

2. Staff are required to be familiar with current Behavior Support Plans (BSPs) before working with youth. This include activities such as: reading BSPs, logs or other current program notes, especially upon arriving on shift at in a new setting; attending treatment team meetings/staff meetings and/or reading meeting minutes; and participating in briefs with incoming/outgoing staff about current issues.

3. Some programs utilize a dedicated physical space for time-away; bedrooms can serve as this space in residential units. Use of time-away must be entirely

voluntary, individual-initiated or requested for the utilization of the individual's Safety Plan, coping skills or other self-regulation strategies. Involuntary isolation or separation from others is considered seclusion and is not tolerated. Vanderheyden does not utilize 'time-out' rooms.

B. TCI Training

1. Initial TCI training including the physical component is 28 hours. Employees are required to complete this training within 90 days from their hire date. Employees not yet trained in TCI will be scheduled with TCI trained employees. Each employee who has completed the initial training must also complete six to eight (6-8) hours of refresher training every six (6) months. Team members must complete both a written and observation test to demonstrate competency.

2. Any employee who has routine contact with youth and as a primary function of their position engages in direct supervision of youth in a SED or OCFS licensed programs will complete full TCI training and certification, including:
   - Program Supervisors & Managers
   - Safety Team Members
   - Direct Support Professional
   - Administrators on Duty (AODs)
   - Teachers, Teacher Aides, Assistants

3. Personnel who have regular and significant contact with individuals, including nurses, administrators, clinicians, case coordinators, and food service personnel will be eligible to complete TCI training in de-escalation techniques.

4. All Vanderheyden personnel assigned to or having contact with OCFS or SED Licensed programs, including administration, will receive annual training on this policy.

5. TCI Instructors must complete a five-day Train-the-Trainers program offered through Cornell University's Family Life Development Center and receive notice of certification by the Residential Child Care Project. This documentation and all subsequent refresher training documentation kept in Vanderheyden electronic training tracking system.

6. The TCI curriculum includes training in:
   - Crisis definition and theory
   - De-escalation techniques including non-verbal and non-physical techniques

- Self-protection skills
- Physical restraint techniques
- Signs of medical distress during restraint, including asphyxiation.

Please refer to the TCI Curriculum for a full list of training topics.

7. Records of the successful completion of TCI training and certification are maintained and updated by the Learning and Development Department via Relias, an electronic training tracking system. Program administrators are required to ensure staff attend training refreshers in compliance with this policy.

8. Any team member that does not attend training or does not demonstrate competency in all portions of the training required for their job title are marked incomplete on the training roster. The trainer will make specific comments in the Instructor Remarks section of the Training Roster indicating the specific de-escalation skills, self-protection skills, and/or physical restraint techniques as not satisfactorily performed. Employees, who have not satisfactorily completed training, are not authorized to use physical restraint.

9. Failure to attend training as assigned may result in disciplinary action. Vanderheyden reserves the right to request an updated Fit for Duty form as documentation of temporary or permanent health/medical conditions which impact competency in TCI.

10. Ongoing opportunities exist (direct observation, camera reviews, and post-restraint administrative reviews) for supervisors to evaluate team members' competency in the use of de-escalation skills and physical restraint techniques. Training, coaching, and supervision, will be ongoing as appropriate, to address deficiencies. Team members that demonstrate deficiency or lack of competency must receive remedial training to assist them in meeting the standards of competency.

C. Continuum of Interventions

- Each individual will receive a clinical and physical health assessment within 24 hours of admission. Each individual will also receive a physical examination within seven days of admission unless the individual has been examined within

ninety days prior to the admission date, and a copy of that examination is submitted during intake.

- A BSP will be developed within 72 hours of a child being placed in care, and will include:
  - Descriptions of current functioning and past trauma of the youth
  - Indications of potential stressors, and potential responses to those stressors, including to potential response to various forms of staff intervention.
  - Preferred de-escalation strategies and interventions identified as likely to be successful for each youth.
  - Limitations or prohibitions on use of restraints identified during the intake process including during the clinical and/or physical assessments.

- If use of a physical restraint is limited or prohibited due to medical or clinical reasons, the BSP will specifically address options available to team members in the event an individual exhibits an acute physical behavior. This may include the use of protective interventions, requesting an ambulance, police, etc.

- Following admission, youth are assessed throughout their stay regularly and as needed when there is a change to their medical and/or mental health condition that may affect use of restraint. Such assessments will occur immediately, or as soon as practicable, upon notification of the change in medical or mental health condition that may affect use of restraint, but no later than 24 hours upon change in their condition.

- All information contained within the BSP is reviewed and modified at least monthly by the assigned clinician, and as soon as practical after each use of restraint. Potential modifications to BSPs will be discussed in interdisciplinary treatment-planning meetings. Current plans will be available for appropriate staff to review at any time while they are providing care.

- Program Administrators will maintain a master listing of all youth who have limitations on the use of physical interventions. The list shall contain the name of the youth and the specific limitation(s) on the use of physical interventions, and be available to staff providing supervision.

- Staff will utilize intervention strategies that are guided by, but not limited to, the youth's BSP when proactive supervision does not prevent youths' agitation. Interventions at this stage should support effective communication, problem solving and conflict resolution, and prevent power struggles.

- Whenever possible, clinical staff including the Clinician on Call if after hours should be consulted and, if possible, assist with de-escalation efforts.

- Whenever possible, nonverbal and verbal de-escalation skills and interventions must be utilized prior to and throughout the course of a physical restraint unless otherwise indicated in the youth's BSP. Whenever practical, staff must give the youth the opportunity to self-regulate their behavior prior to utilizing physical intervention strategies. Strategies taught in TCI include:
  1. Nonverbal Techniques: Silence, Eye Contact, Tone of voice, Facial Expression
  2. Encouraging/Eliciting: Door Opener, Open Questions, Closed Questions, Minimal Encouragements.
  3. Understanding Responses: Reflective Response; Empathic Response and Summarization
  4. Behavior Support Techniques: Managing the Environment, Prompting, Caring Gesture, Hurdle Help, Redirection & Distraction, Proximity, Directive Statement and Time Away

- Vanderheyden authorizes the use of a continuum of physical interventions ranging from least restrictive and least likely to cause harm to more restrictive physical restraint techniques including supine restraints. If the use of physical intervention is authorized per this policy, staff must use techniques appropriate to the level of risk presented by the youth and consistent with the youth's BSP, using the least amount of force necessary to stabilize the youth or situation.

- Vanderheyden authorizes use of the following restraints, as they are defined in the TCI curriculum: Standing Restraint, Team Supine Restraint, Two-Person Seated Restraint (utilizing a wall), Small Child Restraint (against the wall), Small Child Restraint.

- Modifications to an approved restraint technique to meet the specific needs of a youth must be specifically approved by the appropriate licensing entity.

D. Circumstances When Physical Restraint May Be Used

1. The use of physical restraint is limited to circumstances where all approved proactive, non-physical interventions have failed to de-escalate a youth who poses a danger to him/herself or others, unless the circumstances of the incident render the use of non-physical interventions impractical due to the imminent danger of serious injury.

2. Restraints may only be used when the behavior clearly indicates the intent to inflict physical injury upon oneself or others or otherwise jeopardizes the safety of any person [18 NYCRR 441.17(a)(2)] such as:
   - Youth is assaulting others
   - Youth is engaging in self-injurious behavior
   - Youth is imminently likely to jeopardize the safety of another person through the escalation or incitement of others
   - Youth is physically attempting to leave the boundary of a residence for the purpose of jeopardizing their safety or the safety of others

E. Actions When Faced With the Possible Need to Use Physical Restraint

1. Staff must demonstrate emotional control via voice volume, pitch and tone, facial expressions, and gestures regardless of the physical or emotional state of the youth. Staff must preserve the youth's personal space while conducting de-escalation techniques, provided the youth is maintaining safe behavior.

2. While maintaining safety and responding to youth behavior, staff must remain patient and are required to consider and employ alternatives to physical intervention.

3. Staff must use proactive, non-physical interventions, as specified in the youth's BSP to resolve conflicts and crises, unless the circumstances of the incident render their use impractical due to the imminent danger of serious injury.

4. Staff are authorized to utilize the self-protection skills taught in the TCI curriculum in response to physical attacks by youth.

5. Staff must clearly direct unaffected youth away from the crisis whenever possible. Depending on the location of the incident, this may mean directing them to another room, another floor, or another building. Staff not involved in managing the crisis should guide uninvolved youth away and continue to provide appropriate supervision.

6. Staff must stop at the lowest level of intervention and use only the minimum amount of time in restraint necessary to stabilize the youth or situation, and must reduce the level of intervention used as the youth and situation stabilize. Whenever practical, staff must give the youth the opportunity to self-regulate behavior prior to utilizing a greater degree of intervention.

7. When there is the potential for the use of physical restraint, staff must immediately call for assistance from the Administrator On Duty (AOD), Safety Team (SED only) and/or other employees in the vicinity. Staff must work to avoid the use of physical restraint until assistance arrives unless the circumstances of the incident require immediate response due to the imminent danger of serious injury.

8. Staff must not enter a youth's room to confront negative behavior except to prevent a youth from physically harming him/herself or another person. Staff is still required to take all appropriate actions as indicated on youth's BSP and utilize emergency response procedures if needed.

9. If a youth is unclothed at any time during de-escalation or physical restraint, a staff of the same gender as the youth will be involved in the de-escalation and/or restraint, whenever feasible. Reasonable efforts must be made to safely cover the youth.

10. Staff must be aware of the physical environment when addressing a youth's behavior and be cognizant of impediments that may exist (e.g., furniture placement, walls, other youth).

11. Only qualified, TCI certified staff are authorized to utilize physical restraint techniques within the bounds of their training.

12. Physical restraint may be used off grounds, in the community setting if youth experience an acute physical behavior. Staff must be mindful of the circumstances and environment, and balance the safety needs of the community, the youth, and themselves.

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

14. If a physical restraint lasts more than 20 minutes or, two or more restraints occur within a short time period, staff must consult with a clinician or clinical-on-call. Use of a physical restraint for more than 20 minutes requires clinical reauthorization.

F. Safety Precautions

1. Two or more staff members will be involved in all physical restraint. If fewer than two staff are available, a restraint cannot be administered.

2. If a youth complains of pain, staff must adjust their position to immediately remove pressure from the area of complaint.

3. Medical emergencies as noted below always override the physical restraint and require staff to call for medical assistance. Staff must continually monitor whether a youth is breathing, is responsive, and can speak. At any sign of a health emergency including the difficulty breathing, no breathing, vomiting, and loss of consciousness, the restraint must be released and medical care must be sought including calling 911, starting CPR, and giving first aid.
   - If a youth vomits, staff will release the restraint and sit the youth up or help the youth to his/her side.
   - If a youth becomes incontinent, staff will look for an indication of medical emergency, such as loss of consciousness.
   - If a youth appears to be experiencing an active mental health crisis (e.g., actively psychotic or dissociated) staff must call a clinician.

4. Staff are not to attempt physical restraint in the following circumstances:
   - When prohibited by this policy
   - When limited or prohibited in the individual's BSP
   - When the size differential is too great to safely administer the technique
   - When the physical environment has hazards
   - If staff is unable to remain calm and in control of their own actions
   - When the individual has a weapon capable of inflicting serious injury

5. If staff cannot use physical restraint in response to an acute physical behavior for any reason, including those listed above, they are to clear the area, continue to attempt to use de-escalation techniques, and maintain supervision until additional assistance (other staff, clinician, police, ambulance, and etc. arrives)

G. Post-Physical Restraint Medical Response

1. The post-restraint medical response is comprised of two components with separate purposes:
   - Assessment- to identify and treat injuries.
   - Health Review- to collect the youth's perspective of what happened during the crisis, and how they feel they obtained any injuries. All youth must receive a post-physical restraint health review.

2. In most cases the Assessment and the Health Review will occur simultaneously. However, medical needs must be attended to first. The health review will occur as soon as is practical following the receipt of medical care. (ex. upon return from ER)

3. The Assessment and Health Review will occur in the Health Services (HS) department or in the school nurse's office when possible. If the Health Review cannot take place at the HS Department (i.e. youth refuses to go), an RN will ensure that the review occurs in another private and confidential space (ex. empty classroom, youth's bedroom.)

4. Staff who were involved in the physical restraint will not accompany youth to the Assessment/Health Review. Witnesses to the incident will not accompany the youth unless no other uninvolved staff are available.

5. The accompanying Staff must afford the youth and RN privacy during the Assessment/Health Review and remain outside of the examination area and out of earshot so that a confidential interview may occur.

6. Assessment**:** If it appears that an individual may have sustained an injury immediately prior to or during the use of a physical restraint, an assessment by a nurse will be performed as soon as possible [18 NYCRR 441.17(i).] If a nurse or physician is not immediately available, the nurse-on-call will be contacted for further instructions.

7. First Aid will be administered immediately by trained staff if a youth, staff member or visitor appears or claims to be injured.

8. Youth must receive immediate medical care following an incident of physical restraint when:
   - The youth requests medical attention
   - The youth complains of injury or pain, or staff observe injury or pain
   - The youth is visibly injured
   - The youth claims difficulty breathing or staff observe injury or pain
   - The youth demonstrates lack of or altered responsiveness
   - The youth vomits
   - The youth displays incontinence
   - The youth demonstrates an inability to speak

- The youth indicates that he or she lost consciousness or was observed by team members to have lost or had altered consciousness during the restraint
- Activity such as head banging, colliding with furniture, falling or other potentially injurious behavior occurs before, during, or after the restraint
- The youth exhibits behavior suggesting the need for a mental health evaluation and/or treatment. This may include, but is not limited to, the report or observation by others of emotional or behavioral distress; disorientation to person, place, time, or situation; incoherence; demonstration of bizarre behavior; continued mood or behavioral dysregulation

9. AOD/School Administrators will immediately arrange to send an individual out for medical attention at a community provider (Urgent Care, Ortho NY, ER etc.) if directed by a Nurse, Nurse On Call, or if in their discretion they determine the injury is too significant to await further direction.

10. If an RN is not present to examine the youth following the use of physical restraint, the AOD/School Administrator will observe the youth for injuries within one hour of the incident. AOD/School Administrator will consult with the Nurse on Call during the observation.

11. Youth retain the right to refuse or delay health assessment. In the event a youth refuses assessment, the RN or AOD/School Administrator may observe the youth in situ for obvious injuries or limitations.

12. Findings from the assessment, including observational findings and refusals will be added to the Incident Report (IR) in AWARDs by the RN. Youth do not have access to add to or edit an the IR in the AWARDs system

13. Assessment findings will be communicated on the nursing brief. RNs will develop Care Plans for injuries requiring active care or monitoring, and will ensure staff receive appropriate training (ex. removing brace to shower)

14. Health Review: When an RN is on duty, the youth must receive a post-restraint health review within one hour of the end of the conclusion of the restraint, unless extenuating circumstances prevent assessment within one hour. When no health staff is on duty, the health staff must see the youth as soon as practicable the next day

15. When conducting a Health Review, the RN must ask:
    - What happened?
    - Do you have any injuries or pain?
    - How did you get this injury? (Concentrating on the actual cause of the injury, beyond 'the restraint.')
    - If an injury is observed and is not reported by the youth, RN must inquire as to the source of the injury.

16. If no health service personal is on duty, an uninvolved AOD/School Administrator will ask the youth:
    - Do you have any injuries?
    - How did you receive this injury?

    The youth's responses to these questions will be sent via email to the Program Director and added to the AWARDS IR. A justification for AOD/School Administrator conducted the Health Review in lieu of Nursing must also be documented.

17. Youth retain the right to refuse or delay the Health Review. Refusals will be documented on the IR by the RN. Youth do not have access to add to or edit an the IR in the AWARDs system.

18. If RN or AOD observe injuries that appear to be inconsistent with the report of the incident, if the use of physical restraint appears to have been unauthorized, or if a youth makes an allegation of abuse, they will document the allegation, make appropriate notifications, and report the matter to the Justice Center's Vulnerable Persons Central Register (VPCR), in accordance with the Protection of People with Special Needs Act (Laws of 2012, Ch. 501).

H. Photographs

1. Photographs will be taken of any youth who was physically restrained for the purpose of documenting injuries, or lack thereof, and to visually identify the youth.

2. Photographs will be taken of each youth involved in a use of physical restraint incident, during the post-physical restraint health review, regardless of whether the youth has or claims any injuries.

3. Photographs will be taken by an RN or LPN when they are on duty with a digital camera maintained and secured by the Health Services Department.

4. Two full body photos (one front and one back), fully clothed, will be taken to clearly identify the youth. Youth should be instructed to remove face coverings, hoods, etc. to allow for clear identification. Refusal to comply can be considered as refusal to be photographed, unless there are injuries.

5. In all instances, two photographs taken of each view of a youth's injury or purported injury, one close enough to show detail, and the second to show the location & scale relative to other body parts. (Ex. a picture of the youth's leg, and a close-up of the youth's knee.)

6. When possible, photographs should include an object that provides a perspective for the scale/size of the injury.

7. Photographs will be printed and each photograph will be labeled legibly with the following information:
   - The name of the youth photographed
   - The date and time of photograph was taken
   - The IR Number OR the date and time of the relevant incident
   - The name, title, and signature of person taking the photographs

8. Health Services will take additional photographs as the injury evolves/resolves at their discretion or at the direction of an investigator.

9. Completed photographs will be uploaded to the restraint packet and filed in the youth's medical record.

10. All full or partial refusals to be photographed should be documented on the IR by the RN. Youth do not have access to add to or edit an the IR in the AWARDs system.

11. The BSP must include any limitations to the taking of pictures as describe in this procedure, and a clinical justification for those limitations.

I. Life Space Interview (LSI)

1. Staff with the most involvement in the physical intervention or crisis will conduct the LSI utilizing the processing strategy IESCAPE: LSIs are an element of TCI that intend to teach the youth positive coping strategies to replace "pain-based responses". The LSI should be completed as soon as the individual is calm enough to participate.

2. The LSI Steps
   - (I)Isolation- Isolate the conversation for confidential reasons.
   - (E)Explore the young person's point of view
   - (S)Summarize the Feelings and Content
   - (C)Connect the feelings to the behavior
   - (A)Alternative behaviors discussed
   - (P)Plan developed/practice new behavior
   - (E)Enter the young person back into program

3. Completion of the LSI will be documented on the Incident Report

J. Notification and Documentation

1. If not notified as the acute physical behavior escalated, the AOD/School Administrator will be notified immediately after the situation is stabilized.

2. As soon as possible following the use of restraint, but prior to the end of shift/school day, an Incident Report (IR) will be written by the staff with the most knowledge of the entirety of the incident. Additional staff present will be listed as witnesses on the IR.

3. Any staff who witnesses or participates in an incident involving restraint will submit a statement, independently and without collaborating with other staff, summarizing their knowledge, observations, participation and perspective on the incident including what lead to the restraint, the de-escalation strategies employed, the physical restraint technique used, a description of the restraint, and the immediate aftermath after releasing the restraint.
   - Typed statements can sent as an email directly to the Quality Assurance Department (QA) at QAInvestigations@vanderheyden.org
   - Handwritten statements must be legible, signed, dated. Statements can be scanned to the QA OR secured in an interoffice envelope and left int the QA mailbox (1st floor of the Old School)

4. Information entered onto the IR or in a statement will include, but is not limited to, the following:
   - Precipitating factors and youth's behavior prior to the restraint
   - The de-escalation/least-restrictive techniques employed and the youth's response
   - If, when, and what type of assistance was requested

- The justification for the use of physical restraint incl. any limitations per the individuals' BSP
- Communication/De-escalation with the youth during the restraint, including that the purpose of the restraint is to keep them and others safe.
- Ongoing re-evaluation of the person served to justify continued use of restraint/removal of restraint as soon as the threat of harm is no longer present
- Type(s) of physical restraint used
- Whether exigent circumstances were present. If exigent circumstances were present, they must be specifically described
- The identity of staff and youth witnesses, and when they were present
- The youth's behavior during the restraint, and reaction(s) to the restraint
- Any injuries and/or complaints of injuries by youth
- Any injuries and/or complaints of injuries by team members or visitors
- Any observations of the youth's well-being

5. Any incident of suspected child abuse or maltreatment must be reported to the Justice Center's Vulnerable Persons Central Register (VPCR), in accordance with the Protection of People with Special Needs Act (Laws of 2012, Ch. 501; SSL §491).

6. If staff misconduct is alleged, AOD/School Administrator will initiate notifications, including to local law enforcement if necessary, and will draft a staff limitation plan. This includes determining the appropriate level of contact between the employee and the youth, in light of the nature of the allegation and a preliminary assessment of the credibility of the allegation. The determination must be consistent with the safety needs of all youth and may not be based on staff shortages.

7. Notification must be made to the youth's parent, legal guardian, or person legally responsible; the youth's attorney for the child; and custodial agency if applicable for the youth's care regarding the use of physical restraint, information on any injuries sustained, and any contacts with the VPCR. Clinical staff will make notifications whenever possible.
   - <u>School:</u>
     - Telephone notifications will occur as soon as possible and before the end of the school day. If clinical staff are not available, the school psychologist will be consulted as to who will make the notification. Notification will be documented on the Incident Report
     - Within 3 business days of the incident, the Quality Assurance Department will send the appropriate parties a report of the incident.

- Residential:
  - Telephone notifications will occur as soon as possible and within 24 hours of the incident. Notification will be documented on the Incident Notification Form.

8. A digital restraint packet will be created for each incident, and will contain:
   - Administrative Review Form
   - Physical Intervention Video Review Form
   - Completed incident reporting, including the post-physical restraint health review and assessment
   - Identification Photographs
   - Injury photographs and medical documentation, if present
   - Staff witness statements (If applicable)
   - Youth Debrief Form
   - Staff Post Crisis Response Form
   - A copy of the youth's current BSP
   - A copy of the video footage of the event (If applicable)
   - Notification paperwork

9. For residential programs, QA provides an accurate and complete account of incidents involving the use of physical restraint by entering data into the Automated Restraint Tracking System (ARTS) on a weekly basis.

K. Video Surveillance Use

1. Vanderheyden uses surveillance video in its school, administrative buildings, grounds, and common areas of living units for security purposes. Footage is stored and retrievable for 14 days.

2. Camera and server function is routinely audited by the IT department. QA receives regular updates and notices of failures through routine emails

3. Historical video surveillance access is limited to QA and program administrators.

R. Debriefing Process- General

1. Vanderheyden considers debriefing after the use of physical restraint an essential tool to verify the well-being of youth and staff, to determine what caused the event, to become aware of critical events that may upset the youth, to evaluate the effectiveness of interventions utilized, and to proactively mitigate

future events. Debriefing is an integral part of efforts to reduce or eliminate the use of restraints.

2. Vanderheyden will conduct a series of debriefings as soon as practical after each use of physical restraint. Debriefs will be documented on the appropriate form, and stored with the restraint packet

3. If at any point during the debriefing process, potentially abusive behavior is discovered or observed, the Justice Center will be contacted and appropriate safeguards will be enacted.

4. As soon as practical, the youth's Clinician will review the youth and staff debrief forms, and will determine appropriate next steps including discussion of the incident in Treatment Team, modifications to the youth's BSP, or other safeguards.

5. Vanderheyden's multidisciplinary Risk Reduction Committee will conduct monthly reviews of a sample of physical restraint incidents. The committee will examine systemic factors that may have had an impact on the incidents, such as agency policy, facility procedures and practices, environmental issues, treatment approaches, and staff education and training. Meeting discussions will be documented on meeting minutes.

S. Debriefing and Review Process- Residential Setting (OCFS Licensed Programs)

1. Youth Debriefing (Within 12 hours of the Incident) includes an interview of the youth, which is conducted by an uninvolved Clinician, House Manager, Senior House Manager, AOD, or other senior staff. This interview/debriefing is documented on the Youth Debrief Form. The purpose of this debriefing is the following:
   - Identify precipitating factors that may be internal or external to the youth, which contributed to the emotional and behavioral escalation that led to physical intervention.
   - Explore alternate, pro-social behaviors/skills that could have reduced/eliminated the need for staff to utilize the restraint.
   - Explore the manner in which the youth was restrained, the staff involved, and any/all witnesses present.

2. Staff Debriefing (Before the end of shift) will be conducted by a trained administrator as soon as practical after the event. The debriefing administrator is

responsible to complete Staff Post Crisis Response Form. This form must be included in the restraint documentation packet. The purpose of this debriefing is the following:

- Assess staff members' immediate needs (physical and mental well-being).
- Assess the need for emotional support and treatment for trauma for involved youth, staff, and witnesses as necessary (e.g., mental health referral for youth, health referral for staff).
- Discuss the efficacy of staff responses to the incident and the youth's BSP.
- Identify steps needed to return to pre-crisis stability (e.g., physical plant remediation, conducting group meetings, and counseling individual youth).
- Facilitate communication between key staff involved in the incident, support staff and administration as applicable.
- Discuss and identify any need for further resolution between staff and youth or between youth and youth.

3. Initial Administrative Review (Within 24 hours of the Incident) will be conducted by an uninvolved senior administrator such as AOD, Senior House Manager, Assistant Residential Director or Residential Director. If no other administrator is available, an administrator involved solely as a witness may conduct the administrative review. Subordinates will not conduct administrative reviews of incidents involving supervisors. AOD will contact Executive on Call (EOC) if needed to ensure this review is completed timely by appropriate personnel. During the review, the administrator will:
   - Review the Youth Debriefing Form for completeness.
   - Conduct a second debrief with the youth involved in the physical restraint incident. This should include asking about the status of youth's injuries and purported injuries. AOD will consult with the RN on site or Nurse On Call (NOC) if a youth reports new or worsening symptoms.
   - Review the Staff Post Crisis Response Form for completeness
   - Complete their section of the Administrative Review Form. This will include any changes/updates following the second youth debrief, and review of paperwork.

4. Residential Director Review (Within 2 Business Days of the Incident) will be conducted by the Residential Director or designee. If the Residential Director was physically involved in the restraint, the review must be conducted by the Vice President of Operations or the Director of Quality Assurance. During the review, the Residential Director will:

- Ensure the following documents are in the restraint packet file and review for completeness:
  - AWARDS Incident Report incl. health assessment
  - Statements from all Participating Staff
  - Youth Debriefing Form
  - Staff Post Crisis Response Form
  - Administrative Review Form
- The Residential Director will complete their section on the Administrative Review form, including any initial recommendations such as:
  - Further investigation of incident
  - Enhanced supervision of staff
  - Documented instruction
  - Disciplinary action for staff or youth
  - Conflict resolution for staff and youth
  - Staff training

5. Quality Assurance Review (Within 5 Business Days of the Incident) QA will review available surveillance footage and the completed restraint packet as soon as possible following the incident.
   - QA will complete a Physical Intervention Video Review Form summarizing the video days/times reviewed and the findings, including if the restraint was not in view of cameras or was not captured on camera because of technical issues. This document will be preserved into the digital restraint packet.
   - Once the restraint is located, QA will request IT preserve all recorded video into the restraint packet coverage of the physical restraint incident including, if possible, the actions leading up to the use of physical restraint.
     - For restraints occurring within view of multiple cameras, QA staff will determine the best view, and may request multiple views when necessary.
     - When saving the incident, the following will be considered:
       - Is there sufficient video of events leading up to the incident being reviewed?
       - Does the video provided show that the incident has concluded?
       - If there is more than one camera with a view of the incident, should multiple views be preserved to fully capture the incident?
   - QA will confirm that all allegations of abuse or neglect or significant incidents have been reported to the Justice Center's Vulnerable Persons Central Register (VPCR), in accordance with the law.

- QA will communicate with the Residential Director or designee after their review of video and documentation, and may make additional recommendations. Consideration will be given to whether there were exigent circumstances. Consideration will also be given to whether the staff used reasonable efforts to apply an approved technique but was not successful in doing so.

T. Debriefing and Review Process- School

1. Staff Debrief (Within 2 School Days of Incident) Director of Education or Designee will debrief with the staff involved in the incident involving restraint. This discussion will include antecedents, de-escalation techniques used, and planning/reducing future need for restraint. This will be documented on the Staff Post Crisis Response Form

2. Youth Debrief (Within 3 School Days of Incident) The Youth's clinician will coordinate a mediation for the youth and the staff involved in the restraint. The clinician will document this mediation in a Progress Note in AWARDs. The clinician will also document if a mediation is not clinically appropriate or if the youth refuses to participate.

3. Quality Assurance Review (Within 5 Business Days of the Incident) QA will review available surveillance footage and the completed restraint documentation.
   - QA will complete a Physical Intervention Video Review From summarizing the video days/times reviewed and the findings, including if the restraint was not in view of cameras or was not captured on camera because of technical issues. This document will be preserved into the digital restraint packet.
   - Once the restraint is located, QA will request IT preserve all recorded video into the restraint packet coverage of the physical restraint incident including, if possible, the actions leading up to the use of physical restraint.
     - For restraints occurring within view of multiple cameras, QA staff will determine the best view, and may request multiple views when necessary.
     - When saving the incident, the following will be considered:
       - Is there sufficient video of events leading up to the incident being reviewed?
       - Does the video provided show that the incident has concluded?
       - If there is more than one camera with a view of the incident, should multiple views be preserved to fully capture the incident?

- QA will confirm that all allegations of abuse or neglect or significant incidents have been reported to the Justice Center's Vulnerable Persons Central Register (VPCR), in accordance with the law.
- QA will communicate with the Director of Education or designee after their review of video and documentation, and may make additional recommendations. Consideration will be given to whether there were exigent circumstances. Consideration will also be given to whether the staff used reasonable efforts to apply an approved technique but was not successful in doing so.

4. Administrative Review (Within 10 School Days of Incident) Director of Education or designee will review the incident involving restraint, the relevant documentation, any video surveillance, and any recommendations from QA.

U. Documented Instruction

1. In cases where staff exhibit deficiencies in technique (de-escalation skills, physical technique, or restraint monitoring), but those deficiencies do not constitute abuse, the Residential Director and/or QA will refer the staff member for documented instruction (DI), using the form Documented Instruction Form. DI is not a disciplinary procedure, and it is not employee counseling. The DI is meant to be instructive, and it is not to be considered as punitive or disciplinary action.

2. The DI must be provided by a certified trainer to address the observed technique deficiency(ies).

3. Staff who exhibit deficiencies in physical skills techniques will be given a Staff Limitation, prohibiting them from using physical restraint until they receive additional instruction and evaluation on the proper techniques.

4. Staff who exhibit deficiencies in de-escalation or monitoring techniques are not prohibited from using physical restraint.

V. Restraint Reduction Committee (RRC)

1. Vanderheyden's RRC will meet at least monthly to review a sample of incidents that involve the use of physical restraint. This will include reviewing the incident report, video, photographs, and other documentation. RRC will look for systemic trends,

opportunities for training, and other interventions with the intention of reducing future restraint use. Meeting minutes and/or records will be stored digitally.

2. RRC will be comprised of an interdisciplinary group of agency personnel, but will include at least 1 representative of QA, 1 representative of the Learning and Development Department, and 1 representative of each program: RTC, CS-OCFS, and School.

3. When available, RRC will also review reports on restraint use, training compliance, clinical trends, and other relevant topics.

4. RRC will have the ability to make quality improvement recommendations to other departments. The QA Representative or other designee will monitor the status of those recommendations, including their completion.

W. Data Collection/Trend Analysis

1. Vanderheyden QA will review data from ARTS to improve supervision and training of staff, guide staff discipline, and make policy or programmatic changes.

2. Vanderheyden QA will analyze use of restraint, and publish results to internal stakeholders including Executive Team and the Board of Directors via the Program Operations Committee, at least annually. Topics for review may include trends including patterns of use, history of use by personnel, environmental contributing factors, program design contributing factors, and areas in need of performance improvement.

X. Plan to Eliminate Restraint Use:

1. Vanderheyden and its stakeholders feel that continuation of use of physical restraint on an emergency basis is necessary for the overall safety and well-being of the individuals in care. This need will be reviewed no less than every 5 years.

2. Should Vanderheyden find that emergencies necessitating the use of physical restraint decrease, the following elimination plan will be enacted:
   - Following a period of six (6) calendar months with zero (0) reported occasions of the use of physical restraint, Vanderheyden will begin the process of notifying the Board of Directors and affected State Oversight Agencies, amending policy, creating alternate emergency protocols,

evaluating appropriateness of placement, adjusting admission criteria, developing reimplementation criteria and plan, and making other preparations for a moratorium.

- Following an additional period of zero (0) occasions of restraint use in six (6) calendar months, or a period of twelve (12) months from occasion of last use, Vanderheyden will implement a temporary moratorium on all use of physical restraint use to last six (6) calendar months.
- Following a six (6) calendar month moratorium, or a period of eighteen (18) months from occasion of last use of physical restraint, Vanderheyden will conduct a comprehensive review on the safety and well-being of individuals in care, as well as employees, local law enforcement, and other stakeholders.
  - This review will focus on the change in outcomes from before and after elimination of restraint use.
  - The moratorium on use of physical restraint will continue during the review process.
  - This review will be completed with sixty (60) days, and presented to the Executive Team, Board of Directors and other stake holders within sixty (60) days of its completion.
- With the approval of the Executive and Board of Directors, the moratorium will be extended for a period of one (1) year from the date of full approval. The moratorium will be extended annually, based on the process above, pursuant to positive outcomes for individuals in care. After no more than (10) extensions, Vanderheyden will seek approval for permanent elimination of physical restraint.
- Failure to demonstrate increased safety and well-being of individuals in care during a comprehensive review could trigger a reimplementation of the use of physical restraint.

Y. Communication of Policy

1. This policy will be posted on Vanderheyden's website, provided to individuals at the time of intake, and hung when appropriate, including in the main office of the school.

V. FORMS

Youth Debrief Form
Staff Post Crisis Response Form
Administrative Review
Physical Intervention Video Review Form
Documented Instruction Form

VI. REFERENCES

18 NYCRR 441.4 (a), 441.9, & 441.17
Child Abuse Prevention Act of 1992
Protection of People with Special Needs Act (2012, Ch.501)
Rules of the Board of Regents Section 19.5
Regulations of the Commissioner of Education 100.2, 200.1, 200.7,200.15, and 200.22
Employee Interactions with Individuals Served Policy
Professional Boundaries Policy
Procedures for Supervision of Individuals Served
Student Supervision Procedures
Institutional Abuse/Neglect Policy
Mandated Reporting Policy

Karen Carpenter Palumbo
President and CEO

9/27/23
Date

VANDERHEYDEN
Giving new life to youth, adults and families

Restraint Packet- Youth Debrief Form

Youth Name: _____ Date: _____ / ____/____

Staff Leading the Debrief: _____

Debrief must be lead by an UNINVOLVED Clinician, House Manager, Senior House Manager, AOD, or other senior staff. Please note youth responses, including 'I don't know' and/or if the youth refuses to answer.

Does the youth have injuries resulting from the restraint? (Circle one) Yes No

If yes, is the youth satisfied with the medical care received? (Circle one) Yes No

If no, what more can be done? _____
_____
_____

What internal forces may have contributed to the incident? (Ex. mental state, needs, feelings, diagnosis, etc.)
_____
_____

What external forces may have contributed to the incident? (Noise, behavior of others, unsettled environment, etc.) _____
_____

What coping skills, safety plan actions or other behaviors could have reduced/eliminated the need for staff to utilize the restraint. _____
_____
_____

Describe what happened during the restraint. _____
_____
_____

How did you feel while being restrained? _____
_____
_____

What staff were involved in the restraint? _____
_____

Where there any other witnesses? _____
_____

Restraint Packet- Staff Post Crisis Response

Staff Name: _____ Date of Debrief: ___ / ___ / ___ Date of Incident: ___ / ___ / ___

1. Do you have any injuries resulting from the restraint? (Circle one) Yes No
   If yes, please complete an employee IR and submit to HR

2. Do you have concerns about your mental health following the restraint? (Circle one) Yes No
   If yes, please discuss options, including amending safety plan, EAP referral, redeployment, etc.

3. **How did you feel heading into the crisis?** *(1st of the four questions)*

Positive	***Negative***
[ ] "I got this."	[ ] "Oh no, not again."
[ ] "I know I can help them."	[ ] "This kid does not belong here!"
[ ] "I need to do more to help this kid."	[ ] "I wish I had more support."
[ ] "I am so happy that I paid attention in training!"	[ ] "Those trainers suck, they lied to me!
Emotion: E.g. In control (Fill in)	Emotions: E.g. Angry (Fill in)
Self-Doubt	
[ ] "I am not sure what to do."	[ ] "I don't feel safe."
[ ] " I am not sure I am cut out for this"	[ ] "I wish this was just over."
[ ] "I'm really worried about this youth."	Emotion: E.g. Lost (Fill in)

4. **What did the young person feel, need, expect or want?** *(2nd of the four questions)*

What were they feeling? (i.e. angry, sad, frustrated etc.)
Was there an underlying need? (e.g. attention, someone to listen etc.)
Did they expect you to react a certain way?
Did they want something? (e.g. snack, phone call etc.)

5. **What was going on in the environment**? *(3rd of the four questions)*

Crowded? 10=overcrowded 0 1 2 3 4 5 6 7 8 9 10	Noise level? 10=way too loud 0 1 2 3 4 5 6 7 8 9 10
Routine: 10=routine was way off 0 1 2 3 4 5 6 7 8 9 10	Activities: 0=None 10= lots of positive activities 0 1 2 3 4 5 6 7 8 9 10
Peer-influence: [ ] Peers instigating [ ] Bullying Other? (Fill in)	Staffing: [ ] short staffed [ ] redeployed staff [ ] double shift [ ] adequate

4. **How did I respond?** *(The 4th and final question)*

Behaviors (Observed)	Intervention (Attempted)	Response (Successful or Not)
Triggering Event (Agitation): [ ] raised voice [ ] cursing [ ] pacing [ ] posturing [ ] Other: [ ] CAME in when YP was already showing signs of aggression	[ ] Active Listening [ ] Managing the Environment [ ] Prompting [ ] Caring Gesture [ ] Hurdle Help [ ] Redirection & Distraction [ ] Proximity [ ] Directive Statement [ ] Time Away	[ ] De-escalate [ ] Escalate
Escalation Phase (Aggression): [ ] yelling [ ] threatening others [ ] throwing objects [ ] clenched fists [ ] lewd gesturing [ ] Other: [ ] YP was already at Escalation	**Emotional 1st Aid** [ ] Remained calm [ ] Remained attuned/"dialed" in to their needs [ ] Active Listening (Reflective & Empathic Responses) [ ] Clarify events [ ] Provide encouragement & support to complete task/activity	[ ] De-escalate [ ] Escalate
Outburst (Violence): [ ] throwing objects towards others [ ] putting hands on others [ ] spitting at others [ ] inciting violence in others [ ] self-harm/suicidal ideation [ ] attempting to LWOC [ ] Other:	**Crisis Co-Regulation** THINK? [ ] I got this [ ] I Need to tap out SAY? [ ] Validate feelings [ ]Offer an apology DO? [ ] present choices [ ] take a deep breath [ ] remove the audience [ ] give choices & time to decide [ ] drop or change expectations [ ] step back & use protective stance [ ] moved dangerous weapons	[ ] De-escalate [ ] Escalate_
Did I eliminate an element of violence? [ ] spark [ ]target [ ] weapon [ ] stress		

5. Were these strategies indicated on the BSP? (Circle one) Yes No
   If NO then why were other techniques used? _____

6. Is mediation needed to repair relationships? (Circle one) Yes No
   Between who? _____

7. What is needed to return to pre-crisis stability (e.g., physical plant remediation, conducting group meetings, and counseling individual youth)?_____

8. Looking back, is there anything you would have done differently?

   _____

VANDERHEYDEN
Giving new life to youth, adults and families

Restraint Packet- Administrative Review Form

Youth Name: _____ Date of incident: _____ / ____/____

Administrator: _____ Date of review: _____ / ____/_____

To be conducted by an uninvolved senior administrator such as AOD, Senior House Manager, Assistant Residential Director or Residential Director. If no other administrator is available, an administrator involved solely as a witness may conduct the administrative review. Subordinates will not conduct administrative reviews of incidents involving supervisors. AOD will contact Executive on Call (EOC) if needed to ensure this review is completed timely by appropriate personnel.

Is the Youth Debrief Form Completed? (Circle one) Yes No
Comments: _____
_____

Is the Staff Post Crisis Response Completed? (Circle one) Yes No
Comments: _____
_____

Administrative Youth Debrief:

Please note youth responses including refusals.

What is the status of the youth's injuries? (Circle one) New Improving Worsening
Contact Health Services if new or worsening injuries. Comments: _____
_____

Additional Youth Comments about their treatment before, during , or after the restraint:_____
_____
_____
_____

To Be Completed By the Residential Director or Designee:

Further Action Recommended:

- ☐ Further investigation of incident
- ☐ Enhanced supervision of staff
- ☐ Documented instruction
- ☐ Disciplinary action for staff or youth
- ☐ Conflict resolution for staff and youth
- ☐ Staff training
- ☐ Other: _____

VANDERHEYDEN
Giving new life to youth, adults and families

Physical Intervention Video Review Form

Incident Date	**Video Review Date**	**Reviewed by**
Name of Individual	**Program**	**Incident # / IR Review Date**

Camera Viewed	Time Viewed

Observations from Video

If you were unable to view video footage or the footage wasn't viewed within 5 business days from the incident, please explain below: _____

_____

Learning & Development

614 Cooper Hill Rd. Wynantskill, NY 12198
518-283-6500 x749

Person Requesting Intervention:

Please answer the following questions and return this letter to me by date:

1. Is this request part of an approved corrective action? ☐ Yes ☐ No ☐ Proactive intervention

2. What is the nature of you request? ☐Training ☐Remedial Intervention ☐Team Assessment ☐Skills Assessment ☐ Other

3. Oversight Agency:☐ OPWDD ☐ OCFS ☐ JC ☐ SED ☐ Supervisor ☐ Director ☐VP ☐QA ☐ School

4. Specific concerns? Areas in need of improvement? (See back page for list of specific interventions)

_____

_____

_____

5. Is this an initial intervention regarding your concern? If not, please describe previous interventions.

_____

_____

_____

_____

6. Learning & Development findings, intervention(s), recommendations and outcome:

_____

_____

_____

Team Member Comments:

_____

_____

_____

Signature of Participant:_____(date)_____
Signature of Trainer:_____(date)_____

Please pick the following to review:

SCIP-R		TCI	
Guiding Philosophies/Mission Statements		Setting Conditions	
Behavior Control vs. Behavior Support		Emotional Competence	
Beliefs/Values/Attitudes		Stress Model of Crisis	
Regulations – Abuse/Reporting		Four Questions	
Developing and Sustaining Supportive Relationships		Active Listening	
Supportive and Functional Environments		Behavior Support Techniques	
Guidelines for the Use of Physical Techniques		Emotional First Aid	
Understanding Behavior		Conflict Cycle	
Antecedents		Reactive vs. Proactive Aggression	
Developmental Disabilities		Elements of a Potentially Violent Situation	
Proactive/Active/Reactive		Crisis Co-Regulation	
Calming Techniques		Life Space Interview	
What Team Members Experience During Crisis		BSP	
What to do after Physical Interventions			
BSP			
PHYSICAL INTERVENTIONS		**PHYSICAL INTERVENTIONS**	
Touch		Blocking Punches	
One Person Escort		Arm Releases	
Two Person Escort		Hair Pull Release	
Standing Wrap		Front Choke Release	
Front Choke Windmill Release		Back Choke Release	
Back Choke Release		Head Lock Release	
Head Lock Release		Bite Release	
Front Hair Pull Stabilization/Release		Breaking Up a Fight	
Back Hair Pull Stabilization/Release		Standing Restraint	
Arm Releases		Approach from Behind	
Bite Release		Supine Restraint	
Blocking Punches		Small Child Restraint	
Seated Wrap		Seated Restraint	
Arm Control By One Person or Assistance		**SANCTUARY**	
Front Kick Avoidance/Deflection		Self-Care Plan	
One Person Wrap/Removal		Emotional Intelligence	
Two Person Removal		Nonviolence (Body language/Tone of voice)	
Two or Three Person Supine Control		Parallel Process	
One Person Take Down to Side Control		Safety Plan	
Seated Control to Two Person Supine Control			