



Administrative Policies and Procedures: 27.3

Subject:	Use of Physical Restraint
Authority:	TCA 33-3-104, 33-3-120, 37-5-105, 37-5-106
Standards:	COA: PA-BSM 2, BSM 3, BSM 4, BSM 5, BSM 6; DCS Practice Standards: 7-100A, 7-105A, 7-121C, 7-122D, 7-200A, 7-201A, 7-204A, 7-215C, 7-216C, 7-217C, 7-218C, 7-219C, 7-221C, 7-222C, 7-227C, 7-228C, 7-229C; JCAHO Behavioral Health Standard: TX.7.1 (2001)
Application:	To All Department of Children's Services Employees (<i>Except Employees in DCS Youth Development Centers</i>) and Contract Providers

Policy Statement:

Physical restraint shall be used only in an emergency situation, when all other treatment efforts have failed, and when there is imminent danger of a child/youth harming him/her self or others to ensure the safety and appropriate treatment of all children/youth in custody. Physical restraint must never be used as a means of punishment, discipline, coercion, convenience or retaliation. Non-physical interventions are the first choice of intervention unless safety issues demand an immediate physical response.

Purpose:

To set clear minimal standards and expectations for providers and DCS employees in order to maintain a safe and therapeutic environment for children/youth in all care settings. The use of physical restraint is seen as a restrictive intervention and one that poses a risk to the psychological well being of a child/youth.

Procedures:

A. Organizational leadership	DCS shall ensure that its own facilities and those of its contracting providers: <ol style="list-style-type: none"> 1. Are committed to preventing, reducing and striving to eliminate the use of physical restraint; 2. Have sufficient staffing levels to avoid the unnecessary use of restraint; 3. Have sufficient resources and staff time to ensure that adequate training is provided regarding de-escalation and nationally recognized physical restraint techniques, and 4. Monitor the use of restraint as part of organizational performance improvement activities.
B. Initial assessment	Upon entering custody, an initial assessment shall take place to obtain information about the child/youth that could help minimize the use of restraint. The assessment will include identification of:

	<ol style="list-style-type: none"> 1. Techniques, methods or tools that will help the child/youth control his or her behavior. When appropriate, parents, family members and placement staff may assist in the identification of such techniques. 2. Pre-existing medical conditions or physical disabilities and limitations that would place the child/youth at greater risk during restraint. 3. History of sexual or physical abuse or trauma that would place the child/youth at greater psychological risk during restraint.
<p>C. Emergency use of physical restraint</p>	<ol style="list-style-type: none"> 1. Non-physical techniques shall always be considered the preferred intervention. If physical intervention must occur, the type takes into consideration information learned from the assessment described above. 2. Physical restraint will be used only in emergency situations when a child/youth is at risk of self-harm or harm to others, and all other less restrictive interventions have been determined to be ineffective. 3. At least two (2) staff members must be present and able to participate in every physical restraint. Whenever possible, a supervisor should be notified as soon as possible after a restraint is initiated and will supervise and monitor the restraint throughout its duration. 4. In addition, the following requirements must be met in order for physical restraint to occur: <ol style="list-style-type: none"> a) Hospital based facilities (level 4 and acute psychiatric placements) and Psychiatric Residential Treatment Facilities (PRTF): <ul style="list-style-type: none"> ◆ The use of physical restraint must be ordered by a physician or other licensed independent practitioner (such as a licensed psychologist with health service provider, licensed clinical social worker, etc.). ◆ Because a licensed independent practitioner may not always be available in an emergency situation, a registered nurse or other qualified trained staff member may initiate the use of restraint. In this situation, the licensed independent practitioner must be <i>contacted immediately and a verbal order obtained</i>. ◆ The order for the physical restraint is limited fifteen (15) minutes for children less than 10 years of age, and for thirty (30) minutes for children 10 years and older. Time limited orders do not mean that physical restraint must be applied for the entire length of time for which the order is written. Restraints lasting longer than these time frames require clinical justification for continuation and require a new order by a licensed independent practitioner. The agency's restraint reduction committee should internally review these situations. ◆ Orders for the use of physical restraint are never written as a standing order or on a PRN (as needed) basis. b) Residential Treatment Centers: <ul style="list-style-type: none"> ◆ Trained staff may initiate physical restraint by working with the child. A supervisor must be contacted immediately and respond to monitor the

	<p>restraint within five (5) minutes.</p> <ul style="list-style-type: none"> ◆ If the physical restraint goes beyond fifteen (15) minutes, a Program Director or Administrator must be contacted to approve the continuation of the restraint for up to an additional fifteen (15) minutes. The justification for the continuation and the name of the Program Director or Administrator approving the continuation must be documented. ◆ No physical restraints can be authorized beyond thirty (30) minutes unless a licensed independent practitioner conducts a face-to-face assessment. <p>c) Foster and Group Homes:</p> <ul style="list-style-type: none"> ◆ DCS prohibits the use of physical restraint in community settings. However, there may be rare emergency situations in which a foster parent or group home staff member may have to intervene physically in order to keep a child or youth safe (e.g., to separate two youths who are fighting). These situations must be reported to DCS and documented in the Serious Incident Report (SIR) or Critical Incident Report (CIR) web-based applications in accordance with DCS Policy 1.4, Incident Reporting so that the child or youth’s placement and treatment can be reviewed for appropriateness.
<p>D. Monitoring</p>	<ol style="list-style-type: none"> 1. A child/youth in physical restraint must be assessed and monitored continuously by a supervisor not involved in the restraint. All staff involved in and monitoring restraints must be fully trained and certified in a nationally recognized physical restraint method as well as be CPR certified. 2. The assessment includes: <ol style="list-style-type: none"> a) Observation that the child/youth’s airway is not compromised and that no pressure is being applied to the child/youth’s mid-section, neck, mouth, lungs, or chest area. b) Signs of any injury associated with the restraint. c) Circulation and range of motion in the extremities. d) Physical and psychological status and comfort. e) Readiness for discontinuation of restraint. f) If vomiting, a nosebleed or any other complication arises that could compromise the child/youth’s airway, the restraint must be stopped immediately. If the child/youth urinates or defecates during the restraint, every effort should be made to end the restraint immediately. g) Claims by a child/youth that he/she cannot breathe must be taken seriously and responded to appropriately. h) If the child/youth falls asleep during a restraint, the restraint should end immediately.
<p>E. Documentation and notification</p>	<ol style="list-style-type: none"> 1. When a physical restraint is ordered by a licensed independent practitioner in a hospital based setting or a psychiatric residential treatment facility (<i>PRTF</i>), the practitioner must conduct an in-person evaluation of the individual within one

	<p>(1) hour of the initiation of the restraint. The purpose of this in-person assessment by the licensed independent practitioner is to work with the child/youth and staff to determine ways the child/youth can regain control and make any necessary revisions to the child/youth’s treatment plan.</p> <p>2. A child/youth will be released from restraint at the earliest possible time that he/she no longer poses a threat to harming himself/herself or others.</p> <p>3. The nursing or medical staff must immediately assess injuries from a restraint that are noted by staff or reported by a child/youth.</p>
<p>F. Documentation and notification</p>	<p>1. Each incident of physical restraint will be reported to the Department of Children’s Services in accordance with DCS Policy 1.4 Incident Reporting.</p> <p>2. The use of physical restraint will be reported as a serious incident and documented Serious Incident Report (SIR) or on the Critical Incident Report (CIR) web-based applications and submitted to the Family Service Worker, regional resource management, and central office incident management. Providers must notify the DCS Director of Medical and Behavioral Services (or designee) if a child/youth experiences more than one (1) restraint in a day for more than two (2) days in a row.</p> <p>3. Until and unless parental rights are terminated, the child/youth’s parents will be notified of the occurrence of a physical restraint.</p> <p>4. DCS will analyze the use of restraints in DCS facilities and contract provider agencies. Follow-up and further review of restraints will be conducted as needed.</p> <p>5. Providers will report and document injuries to child/youth or staff from restraints as well as gather aggregate data for review by their own internal restraint committees as well as for review by DCS.</p>
<p>G. Debriefing</p>	<p>1. The child/youth and staff shall participate in a debriefing about the physical restraint episode. The debriefing should take place as soon as possible but no longer than twenty-four (24) hours after the restraint occurred. Parents and DCS staff may be involved in the debriefing, as appropriate.</p> <p>2. Evidence of the debriefing must be documented in the child/youth’s record.</p> <p>3. The debriefing shall be used to:</p> <ul style="list-style-type: none"> a) Identify what led to the emergency incident and what could have been handled differently, b) Ascertain the child/youth’s physical well-being, psychological comfort, and right to privacy were addressed, c) Counsel the child/youth involved for any trauma that may have resulted for the incident, and d) When indicated, modify the child/youth’s treatment plan.

	<p>3. Information gained from debriefings is used in performance improvement activities, both at the level of the contracting provider and at the Department level.</p>
<p>H. Training</p>	<ol style="list-style-type: none"> 1. The use of physical restraint should be seen as treatment failure. Programs should train all staff working directly with child/youth in de-escalation techniques. Additionally, some staff may need training in physical restraint methods for times when less restrictive interventions fail. Since restraint is not part of routine care, restraint training is not a routine part of training. At the same time, no staff is to be allowed to restrain without a minimum of sixteen (16) hours of training (to include de-escalation and physical restraint methods). An eight (8) hour refresher course must be given and documented annually. 2. A certified trainer in a nationally recognized crisis intervention program must administer all physical restraint training. Records of staff completion of training must be maintained by the provider and made available for DCS review upon request. 3. All staff trained in physical restraint techniques must not only complete the required amount of training but also demonstrate competency in the safe use of physical restraint techniques and be certified in CPR annually. 4. Training also should emphasize appropriate monitoring and documenting procedures for each restraint episode. 5. Training should occur prior to staff working directly with child/youth, and in an ongoing manner. 6. Physical restraint programs that use pain aversive techniques such as those associated with correctional facilities and populations are prohibited. 7. Techniques that involve restraining child/youth in a face down position in which breathing may be compromised or there is pressure on the child/youth's back or chest may not be used.
<p>I. Internal review</p>	<ol style="list-style-type: none"> 1. All contract provider agencies must incorporate an internal review process of all restraints in their facility as mandated by DCS licensing standards. 2. The internal review process must involve weekly review of all restraints lasting longer than the allowed time frames as well as any restraints that involved injuries to child/youth or staff. 3. Documentation of the agency's administrative review process must be made available to DCS for quality assurance review. This documentation must include: <ul style="list-style-type: none"> ◆ Review of the events precipitating each physical restraint episode, ◆ Other techniques attempted to de-escalate the situation, ◆ Use of authorized procedures, ◆ Staff training, and

	◆ Any corrective action required as a result of the incident.
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Forms:	<i>None</i>
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Collateral documents:	<i>None</i>
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Glossary:	
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<i>Term</i>	<i>Definition</i>
Licensed Independent Practitioner:	<p><i>An individual licensed by the State of Tennessee Health Related Boards as a:</i></p> <ul style="list-style-type: none"> ◆ <i>Medical doctor</i> ◆ <i>Doctor of Osteopathy</i> ◆ <i>Physician Assistant</i> ◆ <i>Certified Nurse Practitioner</i> ◆ <i>Nurse with a masters degree in nursing, who functions as a psychiatric nurse, and is certified to prescribe medication</i> ◆ <i>Psychologist with health service provider designation</i> ◆ <i>Licensed clinical social worker</i> ◆ <i>Licensed professional counselor</i> ◆ <i>Senior psychological examiner</i> ◆ <i>Other licensed mental health professional who is permitted by law to practice independently.</i> <p><i>In addition, to be considered a licensed independent practitioner, the individual must be privileged by the hospital medical staff and governing body to authorize the use of restraint.</i></p>
Physical restraint:	The involuntary immobilization of an individual without the use of mechanical devices.