



POLICY

SUBJECT: Restraints – Use of Physical and Mechanical Restraints
NUMBER: RF-718-26
APPLICABLE TO: All DJS Residential Services Employees

APPROVED: _____

Betsy Fox Tolentino, Secretary

DATE: 03/12/2026

I. POLICY

The Department of Juvenile Services (DJS) allows reasonable use of physical and mechanical restraints within DJS facilities and DJS-licensed private residential facilities to establish and maintain a safe and orderly environment within each facility. Physical and mechanical restraints shall only be used as a last resort.

II. AUTHORITY

- A. [Juvenile Justice and Delinquency Prevention Act \(JJDP\)](#), 34 USC §11102, *et seq.*
- B. Md. Code Ann., Human Services, §§ 9-203, 9-204, 9-227, and 9-237
- C. COMAR 16.18.02.00, *et seq.*
- D. Standards for Health Services in Juvenile Detention and Confinement Facilities, National Commission on Correctional Health Care, 2022
- E. American Correctional Association (ACA) Standards 5-JCF-2A-15, -19, -20, -21, -22, and 5-JCF-5C-48
- F. [American College of Obstetricians and Gynecologists Guidelines](#)
- G. JDAI Detention Standards 2025
- H. SCM Training Manual

III. DIRECTIVES/POLICIES RESCINDED

Use of Physical and Mechanical Restraints, RF-718-18

IV. FAILURE TO COMPLY

Failure to comply with the Department's Policy and Procedures shall be grounds for disciplinary action up to and including termination of employment.

V. STANDARD OPERATING PROCEDURES

Standard operating procedures have been developed and are attached to this policy.

VI. TRAINING

- A. All Resident Advisor, Resident Advisor Supervisor, Resident Advisor Lead, Group Life Manager I and II, Assistant Superintendent, Superintendent, Youth Center Cook, and Transportation employees must be certified in Safe Crisis Management® (SCM), with a passing score of at least 85%, and complete semi-annual refresher training (**See Training Document, Appendix 1**).
- B. DJS Executive Leadership, OIG staff, Nursing and QBHPs must participate in training about SCM that is designed to support their job responsibilities.
- C. Residential Advisors, Residential Advisor Supervisors, Residential Advisor Leads, Group Life Managers I and II, Assistant Superintendents, and Superintendents must be trained to apply handcuffs in both compliant and non-compliant situations.

VII. MEASURABLE OUTCOMES

DJS shall track and review the following outcomes related to the use of physical and mechanical restraints:

- **Frequency and Rate of Restraints**
 - Number and rate of physical restraints (ESPIs) per facility, per month
 - Number and rate of mechanical restraints per facility, per month
 - Restraints per 100 youth-days, disaggregated by facility type
- **Duration of Restraints**
 - Average and median duration of physical restraints
 - Average and median duration of mechanical restraints
 - Percentage of restraints exceeding 10, 20, and 30 minutes
- **Youth and Staff Safety**
 - Number and severity of youth injuries associated with restraints broken out by level of injury
 - Number and severity of staff injuries associated with restraints (including actions leading up to the need for a restraint or applying the restraint itself) broken out by level of injury
- **Disproportionality and Equity**
 - Restraint incidents disaggregated by youth demographics (age, race, gender, disability status) to identify disparities

VIII. AUDIT TOOL

The audit tool shall, at a minimum, assess the following:

- **Authorization and Justification**

- Whether restraint use met policy criteria (imminent danger or escape risk)
- Evidence that prevention and de-escalation strategies were attempted when feasible
- **Technique and Safety**
 - Verification that only approved SCM techniques were used
 - Confirmation that prohibited restraints (chemical, prone, supine, four- or five-point) were not used
 - Compliance with HSAs, pregnancy and postpartum restrictions, and Guarded Care Plans
- **Monitoring and Duration**
 - Accurate documentation of start and end times
 - Required monitoring and fifteen (15)-minute checks documented
 - Appropriate escalation of approvals for extended mechanical restraints
- **Medical and Behavioral Health Response**
 - Timely nursing and QBHP notification and assessments
 - Documentation of injuries, photographs, and follow-up care when required
- **Documentation and Reporting**
 - Completion and accuracy of Incident Reports, Debriefing Forms, and supporting documentation
 - Notification of required parties (Case Management, family, OIG when applicable)
- **Debriefing and Review**
 - Completion of youth, staff, and unit debriefings
 - Evidence of administrative review and corrective actions when deficiencies are identified
- **Corrective Action and Training**
 - Identification of patterns requiring additional staff training, coaching, or discipline
 - Documentation of corrective actions taken and follow-up monitoring

Audit findings shall be reviewed by facility leadership, the Office of the Inspector General (OIG), and DJS Executive Leadership, and shall inform training, policy refinement, and system-wide safety initiatives.

IX. UNION NEGOTIATED POLICY

Yes

X. REVISION HISTORY

DESCRIPTION OF REVISION	DATE OF REVISION
Revised procedures: ● Rescinded RF-02-07, Use of Crisis Prevention Management (CPM) Techniques. Restraints – Use of Physical and Mechanical Restraints replaces RF-02-07 ● Incorporated Directive OP/RS-03-16, Use of Restraints for Emergency Medical Service Transports, amended requirement for consultation with the Executive Directive in cases of EMS transport for mental health emergencies. ● CPM refresher training required annually.	February 28, 2018
● CPM refresher training required twice a year in designated timeframes.	May 9, 2018
● Added requirement to allow Medical Director to grant an exception to restraint of pregnant girls at any time during the pregnancy ● Removed requirement to shackle pregnant girls in labor when the girl presents a risk of escape, in accordance with JJDPA 2018 amendment.	December 4, 2019

DESCRIPTION OF REVISION	DATE OF REVISION
● Policy was updated to reflect changes in restraint procedures that include the new behavioral modification program, Safe Crisis Management® (SCM); ● New definitions added for Directive Touch or Guided Intervention, Emergency Safety Interventions (ESI), Emergency Safety Physical Interventions (ESPI), Least Restrictive Alternative Preventive Intervention and Safe Crisis Management® (SCM) ● Definitions for Qualified Behavioral Health Professions (QBHP) and Restraint updated; ● New procedures added: ○ Staff trained in SCM techniques may use Emergency Safety Physical Interventions (ESPI) when all other prevention/ intervention strategies are not prudent or have not been successful and the youth is in imminent danger to self or others. ○ Prone and Supine restraints are prohibited ○ Staff shall implement de-escalation strategies with the intention of helping the youth return to a state where new coping skills can be developed ○ Staff shall use only the least amount of restriction necessary to manage a youth's behavior that is harmful to them or others. ○ Staff may not place a youth in a physical restraint, including a supine or prone restraint that may constrict or hinder the youth's breathing ○ Staff shall ensure that the youth is gradually released from the physical restraint as soon as the youth is calm, is no longer threatening harm to self or others or is a threat to escape according to the steps learned in training. ○ The Shift Commander or designees shall notify the youth's Case Manager of the youth's restraint by the end of the shift.	December 2024

Policy number updated. Procedures revised: ● Rescinded RF-718-18 ● Authority Updated to include ○ American College of Obstetricians and Gynecologists Guidelines ○ JDAI Detention Standards 2025 ○ SCM Training Manual ● Failure to Comply language updated to meet the new standard. ● Standard Operating Procedures language updated to meet the new standard ● Heading Sections added: ○ Training ■ Information added in accordance with PTEU recommendations. ○ Measurable Outcomes ■ Information added in accordance with Research and Development recommendations. ○ Audit Tool ■ Information added in accordance with OIG recommendations. ○ Union Negotiated Policy ● Definitions Revised and New Terms Added ● New procedures added: ○ Approved Techniques ○ Prohibited Types of Restraints and Limitations on Use ○ Preventive Interventions ○ Use of Physical Restraints ○ Mechanical Restraints in Facilities ○ Use of Physical and Mechanical Restraints for Pregnant and Postpartum Youth ○ Behavioral and Somatic Health Response after the Use of Physical or Mechanical Restraints ○ Staff Responsibilities before, during, and after the use of Restraints ○ Training ● Directives/Policies Referenced updated to include. ○ Behavior Management-Rules and Discipline ○ Seclusion ○ Female Health Care and Pregnancy Management ● Local Operating Procedures Required updated:	March 12, 2026
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DESCRIPTION OF REVISION	DATE OF REVISION
○ No ● Appendices added: ○ Training Document	



PROCEDURES

SUBJECT: Restraints – Use of Physical and Mechanical Restraints

NUMBER: RF-718-26

APPLICABLE TO: All DJS Residential Services Employees

APPROVED: Mathew Fonseca

Mathew Fonseca
Acting Deputy Secretary of Residential Services

DATE: 3/12/2026

I. **PURPOSE**

To establish procedures for the safe and humane use of physical and mechanical restraints when addressing unsafe behaviors of youth in the care and custody of the Department of Juvenile Services (DJS).

II. **DEFINITIONS**

- A. *Chemical restraint* means the use of any chemical (psychoactive or sedative medication or a chemical agent such as pepper spray, foam, etc.) to control behavior or restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychiatric condition.
- B. *Emergency Safety Physical Interventions (ESPI)* means a physical restraint of a youth; the application of physical intervention by one or more individuals that reduces or restricts the ability of a youth to move their arms or legs freely.
- C. *Escape* means an incident during which a youth either leaves the boundaries of a residential facility without authorization or, should the youth be on an off-campus trip, leaves the direct supervision of staff without permission.
- D. *Five-Point Restraints* mean a four-point restraint with the addition of a strap, which is placed over the youth's upper torso and secured to a fixed object.
- E. *Four-Point Restraints* mean restraints that are applied to the wrists and ankles, and are secured to a fixed object.
- F. *Guarded Care Plan (GCP)* means an intervention strategy developed by Behavioral Health staff for youth with problematic behavior, which identifies

Behavioral Health staff for youth with problematic behavior, which identifies triggers, supports, de-escalation strategies, and staff interventions that will potentially assist the youth in making behavioral changes.

- G. *Health Status Alert (HSA)* means a notice from the medical unit about services, activities, programs, or restraints that must be modified for a particular youth due to the youth's health condition. This notice is communicated to Resident Advisors, Group Life Managers, Shift Commanders, Case Managers, Assistant Superintendents and Superintendents, Recreation Specialists, School Personnel, Transportation Supervisors, and others as needed.
- H. *Mechanical restraint* means, for purposes of this policy, using any approved device, such as handcuffs, waist chains, or leg restraints, to limit movement.
- I. *Medical staff* means a nurse, nurse practitioner, physician, or physician assistant who is an employee of DJS or is employed by a medical vendor for DJS.
- J. *Physical restraint* means the application of hands-on intervention by one or more individuals that reduces or restricts the ability of an individual to move their arms or legs freely.
- K. *Postpartum Period* means up to six (6) weeks after birth.
- L. *Preventive Intervention* means any pre-emptive non-threatening step or action used to de-escalate a problem or crisis, including non-verbal strategies, verbal comments/commands or instructions, and directive touch.
- M. *Prone Position Restraint* means a physical hold by which a youth is placed face down on the ground or the floor.
- N. *Qualified Behavioral Health Professional (QBHP)* means staff who perform clinical duties in accordance with their professional scope of training and maintain applicable licensing, registration, certification, and regulatory requirements.
- O. *Restraint* means complete or partial constraint of a person's bodily movement through physical and/or mechanical means.
- P. *Safe Crisis Management® (SCM)* means a training program that teaches staff how to manage challenging behaviors in individuals who may experience a crisis. The program's goals include: preventing and de-escalating disruptive behaviors, intervening safely with individuals who are acting out, emergency intervention to respond to emergency situations, follow-up processing of incidents after they occur, and building positive relationships with individuals.
- Q. *Supine Position Restraint* means a physical hold by which a youth is placed face

up on the ground or the floor.

- R. *Treatment Team* means assigned staff from multiple disciplines that meet to assess the progress and needs of youth in custody, and to ensure the development and implementation of responsive treatment interventions.

III. PROCEDURES

- A. **Approved Techniques** The following SCM techniques are the only approved emergency safety response method permitted by DJS. The only other emergency intervention permitted by DJS is the use of mechanical restraints as outlined in this policy and the [Transportation of Youth – Residential & Community, RF-738-17](#), policy.

1. Evasion/Escapes Types
 - a. Pivot Parry/Evasion Deflection
 - b. Front Choke Escape
 - c. Rear Choke Escape
 - d. Forearm Choke Escape
 - e. Wrist Grab Escapes
 - f. Bear Hug Escape
 - g. Bite Escapes
 - h. Hair Pull Escapes
2. Standing ESPIs
 - a. Biceps Escort
 - b. Extended Arm Assist
 - c. Crossed Arm Assist
 - d. Cradle Assist
 - e. Shoulder Assist
 - f. Upper Torso Assist
 - g. Biceps Assist
 - h. Multiple-Person Upper Torso Assist
 - i. Hook Escort
3. Seated/Kneeling ESPIs
 - a. Cradle Assist to Seated/Kneeling Cradle Assist
 - b. Upper Torso Assist to Seated/ Kneeling Upper Torso Assist
 - c. Hook Assist to Seated/Kneeling Assist
 - d. Seated/Kneeling Biceps Assist
 - e. Multiple-Person Seated/Kneeling Upper Torso Assist
 - f. Leg Assistance sitting up from Face Position
 - g. Side Assist
 - h. Sitting up from Side Assist

B. Prohibited Types of Restraints and Limitations on Use

1. No form of restraint may be used for purposes of discipline, treatment, retaliation, convenience of staff, or punishment.
2. Supine and prone position restraints are strictly prohibited.
3. Chemical restraints of any kind are strictly prohibited.

4. Four- and five-point mechanical restraints are strictly prohibited.
5. Staff performing restraints shall be aware of youth Health Status Alerts (HSAs) which may specify pregnancy or other restraint restrictions due to a youth's underlying medical condition(s).

C. Preventive Interventions

1. In accordance with SCM training, staff shall attempt to incrementally exhaust prevention and de-escalation strategies to defuse potential incidents.
2. When a youth has a Guarded Care Plan and time allows, staff must consult the plan for guidance about strategies to manage the youth's behavior. In keeping with the [Behavior Management-Rules and Discipline. RF-741-18 policy](#), staff must maintain familiarity with Guarded Care Plans for youth under their care.
3. Staff must remain familiar with Health Status Alerts for the youth under their care and maintain the confidentiality of the health information within those alerts.

D. Use of Physical Restraints

1. Emergency Safety Physical Interventions (ESPIs) may be used when:
 - a. all other prevention and de-escalation strategies are not reasonable and necessary, or have not been successful AND the youth presents:
 - (1) an imminent danger to self or others, or
 - (2) an imminent risk of engaging in an escape.
 - b. Staff engaging in an ESPI shall act without:
 - (1) Causing the youth pain or suffering;
 - (2) Restricting the youth's ability to breathe; and
 - (3) Verbal taunting, teasing, or humiliating the youth.
2. Staff may use SCM escape and evasion techniques when needed to protect themselves or others.
3. **Initiating a physical restraint.**
 - a. Only staff who have successfully completed DJS-approved SCM training for the appropriate use of physical restraints and are certified, and who complete all scheduled refresher training, may physically restrain youth.
 - b. Before initiating a restraint, staff shall:
 - (1) Call for assistance. Whenever possible, at least two (2) staff members shall assist with the restraint of a youth to help ensure safety and accountability.
 - (2) Follow the mandates of any HSA or GCP that applies to the youth when deciding what technique to use.
4. **Conducting a physical restraint.**
 - a. When conducting a physical restraint, staff shall use the least amount of restriction necessary.
 - b. Staff shall direct other youth to move away from the restraint incident. (For example, youth may be instructed to move to the door in front of their room, to the wall, or to an area as directed by staff.)
 - c. The highest ranking staff member shall:

- (1) Assign duties,
 - (2) Direct the actions of staff, and
 - (3) Ensure that the following activities are completed, assigning to others as appropriate:
 - (a) Record the time the restraint started;
 - (b) Record the time of assist changes and release attempts;
 - (c) Record specific, measurable and observable behaviors;
 - (d) Prevent the use of any technique prohibited by a youth's HSA.
 - (e) Assess the correctness of the ESPI(s) and communicate any necessary changes;
 - (f) Assess for any possible staff counter-aggression and replace the staff member if necessary;
 - (g) Monitor the youth's level of agitation and mental status,
 - (h) Document monitoring at least every fifteen (15) minutes,
 - (i) Provide for the basic needs of youth (hydration, nutrition, elimination and range of motion); and
 - (j) Watch for and immediately point out any signs of physical distress outlined in section 5.b.
 - d. If an assist to the floor is required, the staff's body weight during the hold must be positioned to the side of the youth's body and not directly on top of the youth.
 - e. Staff shall communicate continuously to de-escalate the youth throughout the restraint, and ask questions to ensure the youth is not in distress.
 - f. If a staff member engages in a form of restraint prohibited by the youth's HSA, they shall notify the nurse immediately.
- 5. Terminating a physical restraint.**
- a. Staff shall terminate any restraint while it is underway if the youth is no longer a danger to self or others and/or is no longer a threat to escape.
 - b. Staff shall immediately release a youth from restraint and contact the on-site or on-call nurse immediately if the youth exhibits signs or symptoms of physical distress, such as:
 - (1) Significant confusion, slurred speech, or disorientation to person, place, or time;
 - (2) Change in skin, lip, or nail bed color (e.g., turning blue or purple or very pale);
 - (3) Decreased level or complete loss of consciousness (e.g., fainting or not able to wake up or respond to a sternal rub);
 - (4) Seizure-like activity (e.g., jerking movements of body, eye deviation/twitching, body stiffening);
 - (5) Serious injury (e.g., obvious fracture or dislocation, swelling or deformity of a body part, audible crack or pop of a bone or joint);
 - (6) Sudden onset of severe pain in an extremity (arms, legs, hands,

- or feet), pelvis, abdomen, back, chest, head, or neck;
 - (7) Significant or unusual bleeding from the nose, ear, mouth, or genital area, or from a visible laceration or cut;
 - (8) Difficulty breathing or not breathing at all (e.g., gasping for air, panting, choking, or unable to talk);
 - (9) Vomiting; or
 - (10) Defecating or urinating on self.
- c. Staff shall immediately release a youth from restraint and contact on-site or on-call QBHP immediately if the youth exhibits signs or symptoms of psychological distress.
- d. If after ten (10) minutes a youth is a danger to themselves or others or at risk to escape and continued restraint is deemed necessary, staff shall change to a different ESPI and notify the on-site or on-call nurse.
- e. If a youth is in a restraint, as soon as the youth is no longer a danger to self or others and is no longer a threat to escape, staff shall conduct either a gradual or timed release from the physical restraint according to the steps learned in training.
- f. At least two (2) staff shall inquire whether the youth has any injuries during and after any restraint.
- g. If a youth remains a danger to self or others or poses a continued risk of escape, mechanical restraints may be applied only as outlined in section E of this policy.
- h. If the decision is made to use seclusion instead of a restraint, any seclusion must be completed in accordance with the [Seclusion, RF-720-18](#), policy.

E. Mechanical Restraints in Facilities.

1. Initiating a mechanical restraint.

- a. Only direct care staff who have successfully completed SCM training for the use of mechanical restraints in facilities following physical restraint may apply mechanical restraints to youth. This does not apply when transporting youth. See [Transportation of Youth – Residential & Community, RF-738-17](#)
- b. Mechanical restraints may be used when all other prevention and de-escalation strategies and physical restraints are not advisable or have not been successful, AND the youth presents:
 - (1) imminent danger to self or others, or
 - (2) an imminent risk of engaging in an escape.
- c. Only shift commanders may authorize the use of mechanical restraints.

2. Conducting a mechanical restraint.

- a. Youth shall never be mechanically restrained:
 - (1) in a prone position;
 - (2) in a way that blocks breathing or the airway;
 - (3) to a stationary object (e.g., a chair, desk, table, or bed); or
 - (4) to another youth.
- b. Mechanical restraints shall not be applied so tightly that they cause

injury, pain, or discomfort.

- c. Mechanical restraints shall not be applied to or near an area of the body that is injured or already in pain such as to a possibly broken arm or leg, sprained ankle or wrist, below a dislocated elbow or hip or shoulder, to the waist if in acute abdominal pain, or over a laceration or sutured area of the body.
- d. If the youth develops difficulty breathing, reposition handcuffs to the front if mechanical restraints are still necessary.
- e. Mechanical restraints in facilities shall be used for the least amount of time necessary.
- f. Youth may not be left in mechanical restraints if they are sleeping.
- g. All staff authorized to use mechanical restraints shall ensure they have immediate access to the key(s) for the restraint device(s) at all times when applying or supervising youth with mechanical restraints.
- h. Staff shall maintain at least one-on-one supervision until restraints are removed.

3. Releasing a mechanical restraint.

- a. Staff shall immediately release from mechanical restraints any youth who exhibits signs of physical injury, nerve compression, or circulatory compromise such as:
 - (1) bleeding from a cut caused by the restraint,
 - (2) visible bruising or swelling at or near the restraint site,
 - (3) significant pain at or near the restraint site,
 - (4) deformity or suspected fracture at or near the restraint site,
 - (5) complaint of numbness or tingling at or below the restraint site (e.g., wrist, hand, fingers, thumb, ankle, foot or toes),
 - (6) lack of blood flow as indicated for example by color change (e.g., blue, purple, white) in a hand or foot where the restraint has been applied, and/or
 - (7) seizure-like activity.
- b. Staff shall immediately release a youth from mechanical restraints as soon as the youth is no longer a danger to self or others and/or is no longer a threat to escape.
- c. Staff shall release the youth from mechanical restraints once the youth is secured safely in a room or other safe place.

4. Time limits for mechanical restraints authorization.

- a. The Shift Commander may authorize the use of mechanical restraints for up to ten (10) minutes.
- b. Any mechanical restraints lasting longer than ten (10) minutes requires
 - (1) Approval by the Superintendent or on-call administrator.
 - (2) Notification of the on-site or on-call nurse.
- c. The Superintendent may authorize a total of two (2) additional ten (10) minute intervals for an additional twenty (20) minutes. Use of mechanical restraints that exceed thirty (30) minutes total time must be approved by the Executive Director for Treatment Services or Detention Programs and every thirty (30) minutes thereafter. In any

circumstance where the approver is unavailable, the person above that approver in the chain of command shall be contacted.

5. **Mechanical restraint equipment.**

- a. Superintendents shall ensure all mechanical restraint equipment is maintained, inventoried, and secured.

F. Use of Physical and Mechanical Restraints for Pregnant and Postpartum Youth

1. Medical staff shall identify youth who are pregnant or postpartum in accordance with the *Female Health Care and Pregnancy Management HC-335-18* policy.
2. Medical staff shall immediately issue a health status alert (HSA) for youth who are identified as pregnant or postpartum.
 - a. The dates of each trimester, if known, shall be specified on a HSA.
 - b. The HSA shall be updated, as needed, to reflect the current pregnancy and postpartum status.
 - c. If the youth does not consent to release information regarding her pregnancy, the HSA will not specify her pregnancy but will list restraint restrictions necessary in compliance with this policy, and only those who need to know her diagnosis will be notified of the pregnancy.
3. Use of physical and mechanical restraints on a youth known to be pregnant or in the postpartum period must be the least restrictive necessary to protect the youth and others from imminent harm and/or to prevent escape.
4. Physical restraints on pregnant and postpartum youth:
 - a. If a physical restraint becomes necessary for a pregnant or postpartum youth, staff shall avoid placing pressure on the youth from the upper chest to the pelvis.
5. Mechanical restraints on pregnant and postpartum youth:
 - a. Mechanical waist and/or leg restraints shall not be placed on pregnant or postpartum youth.
 - b. Youth who are in their *first or second trimester* of pregnancy or *postpartum* may be placed in mechanical wrist restraints unless directed otherwise by the youth's HSA.
 - (1) If the youth does not have an HSA on file, consult with the facility's medical staff.
 - c. Mechanical wrist restraints shall be secured in front of a pregnant youth.
 - d. Youth who are in their *third trimester* of pregnancy shall not be placed in mechanical wrist restraints unless:
 - (1) The Superintendent consults with the Medical Director and both agree that there is credible and reasonable grounds to believe the youth presents an immediate danger to themselves or others, or that the risk of escape is sufficient to warrant the use of mechanical wrist restraints.
 - (2) Approval for restraint use during the third trimester must be

- documented, including the clinical input received and the specific safety concerns that necessitated the decision.
- e. Pregnant youth in mechanical restraints must be supervised by two (2) staff at all times. Staff shall escort the youth by positioning themselves one on the left and one on the right side.
- 6. Any mechanical restraint must be removed if a medical professional indicates that it is interfering with safe provision of medical care for a youth during pregnancy, labor, delivery, or the postpartum period.

G. Behavioral and Somatic Health Response after the Use of Physical or Mechanical Restraints

- 1. The highest ranking staff member involved in the restraint shall ensure that ALL youth are evaluated by nursing and behavioral health staff following a physical or mechanical restraint within the following time frames:
 - a. Upon release of restraint where physical distress has been identified, staff shall immediately request assistance from the nurse and indicate that the situation involves youth physical distress.
 - b. Upon notification of youth distress from a restraint, nursing staff shall respond to the youth in person as soon as possible, but no later than fifteen (15) minutes after notification.
 - c. If staff do not identify a concern of physical distress for the youth, staff must notify the nurse within fifteen (15) minutes of the end of the restraint and document the time at which the nurse was notified . When possible, residential staff shall bring the youth to the nurse's office to complete the assessment.
 - d. Nursing staff shall attempt to complete an assessment of youth involved in a physical or mechanical restraint. The assessment shall be completed no later than forty-five (45) minutes after notification. Staff shall document the time at which the nurse arrived at the scene or the youth was brought to the nurse.
 - (1) A longer response time may be permitted under the following circumstances:
 - (a) there are multiple restraints occurring at the same time,
 - (b) the youth refuses medical care,
 - (c) the youth's behavior is too volatile to have a meaningful assessment,
 - (d) the youth is seeing the QBHP, and/or
 - (e) there is another medical emergency at the facility.
- 2. If medical staff are not on grounds to evaluate a youth following a restraint, the Shift Commander or designee shall contact the on-call medical staff by telephone within fifteen (15) minutes after the end of the restraint, or immediately if physical distress or injury has been reported or observed. The Shift Commander or designee shall:
 - a. Advise them of the restraint and any observed or youth-reported injury.
 - b. Photograph the youth's physical status in accordance with the [Incident](#)

[Reporting- Residential Facilities and Community Operations, CS/RS-900-19, policy.](#)

3. After consultation with medical staff, the Shift Commander shall ensure that youth who are in need of emergency medical attention shall be transported to an emergency medical facility by 911 – Emergency Medical Services or by facility staff as determined by medical staff in consultation with the superintendent or designee and in accordance with the [Transportation of Youth – Residential & Community, RF-738-17, policy.](#)
4. The Shift Commander or designee(s) shall notify the youth's Case Management Specialist of the youth's restraint by the end of the shift.
5. The Shift Commander or designee shall inform a QBHP of a physical and mechanical restraint of a youth within fifteen (15) minutes after the end of the restraint and document the time at which the QBHP was notified. If the QBHP is on site, the QBHP shall assess a youth who has been restrained as soon as possible and no later than forty-five (45) minutes after notification. Staff shall document the time at which the QBHP arrived at the scene or the youth was brought to the QBHP.
 - a. A longer response time may be permitted under the following circumstances:
 - (1) there are multiple restraints occurring at the same time,
 - (2) the youth refuses assessment,
 - (3) the youth's behavior is too volatile to have a meaningful assessment,
 - (4) the youth is seeing the nurse, or
 - (5) there is another medical emergency at the facility.
6. If a QBHP is not on-site, the Shift Commander or designee shall notify the on-call QBHP.
 - a. The on-call QBHP shall complete an assessment by phone with youth as soon as possible, and no later than one (1) hour from notification.
 - b. The Shift Commander or designee shall document the instructions given by the QBHP on the **Crisis Behavioral Health Referral Form (Appendix 2)**.
 - c. A QBHP shall complete a follow-up face to face assessment with the youth the next time a QBHP is on-site.
 - d. The outcome and plan of care, if required, shall be documented on the **Crisis Behavioral Health Referral Form (Appendix 2)**. A copy of the **Crisis Behavioral Health Referral Form (Appendix 2)** shall be placed in the youth's medical file.

H. Staff Responsibilities before, during, and after the use of Restraints

1. **All staff:**
 - a. With knowledge, suspicion, or information about abuse and neglect shall report it immediately and in accordance with the [Reporting and Investigating Child Abuse and Neglect Policy, OPS-913-15,](#)
 - b. Who have participated in or witnessed any use of restraint, other than for transportation, shall complete an Incident Report, in accordance

with the [*Incident Reporting- Residential Facilities and Community Operations*](#), CS/RS-900-19, policy.

2. Shift Commanders/Shift Supervisor shall:

- a. Assess the youth and the situation.
- b. Plan the intervention, when possible.
- c. Direct and cue other staff during the restraint.
- d. Assign the duty of monitoring youth well-being throughout the restraint.
- e. Communicate with the youth throughout the restraint.
- f. Conduct the debriefing with the youth following the restraint.
- g. Ensure that the use of restraints is documented in the unit logbook and the facility logbook.
- h. Ensure the youth has been medically examined by the nurse following a restraint. If medical staff are not on site, contact the on-call nursing or medical staff, and photograph the youth's physical status in accordance with the [*Incident Reporting- Residential Facilities and Community Operations*](#), CS/RS-900-19, policy.
- i. Ensure the youth has been assessed by a QBHP.
- j. Contact the youth's family to inform them about the restraint and document it on the **Family Debriefing Form (Appendix 3)**.
- k. Review incident reports and video surveillance for all incidents of physical restraints to identify any suspected abuse or neglect and any violations of DJS policy and procedures.
- l. Follow procedures to protect the youth, report, and investigate the incident in accordance with DJS policies and procedures.

3. Medical staff shall:

- a. Issue a Health Status Alert for any youth whose health may be impacted by certain restraint practices.
- b. If on-site, upon being called to the scene of a physical or mechanical restraint that has lasted ten (10) minutes or longer, monitor the youth's health status (i.e., check respiration, circulation, responsiveness, neurological status, level of discomfort, compromise to extremities) and the safety of the use of the mechanical restraint(s) for the remaining duration of the restraint and communicate to staff if the restraint is jeopardizing the health of the youth.
- c. After the restraint is over, conduct a health assessment of the youth to determine whether an injury has occurred, provide appropriate nursing care, and refer for further health care or follow-up when indicated (e.g., consultation with on-call physician, emergency room referral, follow-up in clinic).
- d. Photograph the youth's physical status in accordance with the [*Incident Reporting- Residential Facilities and Community Operations*](#), CS/RS-900-19, policy.
- e. Complete and forward to the Superintendent or designee a **Nursing Report of Youth Injuries Form (Appendix 4)**.

4. Qualified Behavioral Health Professional staff shall:

- a. Assess the youth who has been restrained using the **Crisis Behavioral Health Referral Form (Appendix 2)**. A copy of this form shall be placed in the youth's medical file and included with the incident report.
 - (1) If the staff is onsite, the assessment shall occur as soon as possible but no later than forty-five (45) minutes after notification.
 - (2) If the staff is not onsite, the assessment shall be conducted over the phone or virtually within an hour of the notification. The QBHP shall conduct a follow-up face-to-face assessment with the youth the next time a QBHP is on-site.
5. **Facility Case Management Specialists (FCMS) shall:**
 - a. Schedule a Treatment Team review meeting for any youth who has two (2) or more restraint incidents in a week. This review shall occur as soon as possible but no later than one (1) week after the second incident.
 - b. FCMS shall ensure that the Treatment Team identifies precipitating behavior(s) and develops and implements appropriate supportive intervention strategies which may include a Guarded Care Plan.
 - c. FCMS shall track and circulate lists of all youth in the facility who have medically-required restrictions on restraints. FCMS shall coordinate to ensure that this list is updated at least five (5) days per week.
6. **Superintendent or designee shall:**
 - a. Ensure that the facility's operating procedures:
 - (1) include a method of maintaining, inventory and securing mechanical restraint equipment.
 - (2) provide instructions for the issuance and return of mechanical restraint equipment.
 - b. Ensure all mechanical restraint equipment is maintained, inventoried, and secured.
 - c. Review the Incident Report and all available video recordings of incidents involving the use of any physical or mechanical restraint within twenty-four (24) hours of each incident or the first business day following the incident to determine if the restraint was appropriate and in compliance with DJS policies and procedures, and maintain a log to document reviews.
 - d. Ensure that video recordings are saved electronically and retained, as directed by the Deputy Secretary for Residential Services.
 - e. Ensure that any suspicion of abuse is reported in accordance with the [Reporting and Investigating Child Abuse and Neglect Policy, OPS-913-15](#)
 - f. Make the decision, when applicable, to seek the assistance of local law enforcement to manage combative, violent, or out-of-control behavior of youth in a facility.
 - g. Ensure that all incidents are thoroughly investigated and evaluate the

- h. precipitating causes and factors contributing to the use of restraints. Identify, document, and implement any needed corrective actions, including additional staff training on incident management, de-escalation and restraint skills and/or staff discipline.

7. Office of the Inspector General (OIG) shall:

- a. Review for investigation any incident in which it is reported or indicated that staff may have inappropriately:
 - (1) Applied an ESPI restraint technique or used an unapproved technique,
 - (2) Applied a Mechanical Restraint,
 - (3) Used a chemical, prone, or supine restraint, or
 - (4) Used an intervention that exceeds the procedurally authorized response to the behavior.
- b. Investigate any restraint where a youth receives a level 3 injury, and review for investigation any restraint with a level 2 injury. The levels of injury are defined in the [*Incident Reporting- Residential Facilities and Community Operations*](#), CS/RS-900-19, policy.

I. Debriefing

1. Youth Debriefing

- a. Once the youth is calm, the Shift Commander or designee shall have a discussion with the youth to determine behaviors that led to the restraint, and alternative behaviors to avoid escalation and future incidents.
- b. The Shift Commander or designee shall immediately report and respond to any allegations of abuse or neglect made by the youth in accordance with [*Reporting and Investigating Child Abuse and Neglect, OPS-913-15*](#), policy and the [*Eliminating and Reporting of Sexual Abuse and Harassment, RF-701-18*](#), policy.
 - (1) The youth debriefing will be documented on the **Youth - Restraint Debriefing Form (Appendix 5)**.

2. Unit Debriefing

- a. The unit supervisor shall hold a debrief during the next group meeting when the use of a restraint has had a negative impact on a unit. The group meeting shall provide an opportunity for those affected to:
 - (1) Express concerns and ask questions;
 - (2) Review and process expectations for improved unit interactions;
 - (3) Provide involved youth with an opportunity to address the group.
 - (4) The Unit Debriefing will be documented on the **Unit Restraint Debriefing Form (Appendix 6)**

3. Staff Debriefing

- a. The Shift Commander or designee shall conduct a staff debriefing before the end of the shift. The debriefing shall be documented on the **Staff Restraint Debriefing Form (Appendix 7)** and forwarded to the Superintendent.

- b. All staff involved in a restraint incident shall attend the staff debriefing.
- c. The debriefing will focus on the following areas:
 - (1) The emotional and physical well-being of the staff involved in the restraint;
 - (2) Assess if staff are able to continue with their responsibilities on the unit;
 - (3) Provide for program recovery and arrange for new coverage in order to assist the unit in regaining stability;
 - (4) Ask staff to describe in detail what occurred;
 - (5) Complete and review documentation of the restraint; and
 - (6) Review the video recording of the incident with staff to point out areas of good interventions and areas of needed improvement. Video recordings, however, must not be reviewed with staff when there is an allegation of abuse or concern for staff violation of departmental policy and procedures.

J. Administrative Review

- 1. The Superintendent or designee will ensure that a committee that includes nursing, behavioral health, group life manager, and facility case management staff, with all necessary entities represented conducts an incident review that considers:
 - a. Performance of staff involved in the incident;
 - b. The submission of all required documents;
 - c. The correctness of documents;
 - d. Implementation of the youth's Guarded Care Plan if one existed, along with any limitations on restraint ordered by medical or mental health staff;
 - e. Justification for the use of ESPI(s);
 - f. Review of details required on the Restraint Incident Review Checklist;
 - g. Compliance with policies and procedures;
 - h. Provision of verbal and written feedback to staff involved, supervisors, administrators, clinical and treatment planning staff;
 - i. Updates to Guarded Care Plans and completion of a functional behavior assessment if warranted; and
 - j. Evaluation of the effectiveness and appropriateness of staff response to youth behavior and any interventions utilized.
- 2. This meeting may be scheduled in conjunction with the youth workplace violence reduction meetings. See [Youth Workplace Violence Reduction Committee, OPS-909-15 policy](#)

K. Training

- 1. All DJS SCM trainers must be certified by SCM to provide the training they present.
- 2. Staff in the categories of Resident Advisor, Resident Advisor Supervisor, Resident Advisor Lead, Group Life Manager I and II, Assistant

Superintendent, Superintendent, Youth Center Cook, and Transportation must be certified in the DJS-approved SCM techniques. **(See Training Document, Appendix 1)**

- a. Certification requires achieving a score of at least 85% on the evaluation.
 - b. Direct care staff members who do not achieve a score of at least 85% can retake the evaluation up to two additional times.
 - c. SCM entry-level training must be repeated by any direct care staff who do not achieve at least an 85% after three attempts.
 - d. If the staff member is unsuccessful in achieving at least 85% after the second full training and associated retests, they will be separated from the agency.
3. Direct care staff must complete twelve (12) hours of refresher training each year.
 4. Facility leadership, OIG staff, Nursing, and QBHPs shall participate in training about SCM that is designed to support their job responsibilities.
 5. Residential Advisors, Residential Advisor Supervisors, Residential Advisor Leads, Group Life Managers I and II, Assistant Superintendents, and Superintendents must be trained to apply handcuffs in both compliant and noncompliant situations.

IV. RESPONSIBILITY

Superintendents are responsible for implementation and compliance with this procedure within thirty (30) days of issuance.

V. INTERPRETATION

The Acting Deputy Secretary of Residential Services, with the concurrence of the Secretary, shall be responsible for interpreting and granting any exceptions to these procedures, consistent with the requirements of applicable State laws, regulations, and guidelines.

VI. LOCAL OPERATING PROCEDURES REQUIRED

No

VII. FACILITY OPERATING PROCEDURES OR POST ORDERS REQUIRED

- FOP should include where the key is maintained for mechanical restraints.

VIII. DIRECTIVES/POLICIES REFERENCED

- A. *Transportation of Youth – Residential & Community*, RF-738-17
- B. *Behavior Management-Rules and Discipline*, RF-741-18
- C. *Seclusion*, RF-720-18

- D. *Female Health Care and Pregnancy Management HC-335-18*
- E. *Incident Reporting- Residential Facilities and Community Operations, CS/RS-900-19*
- F. *Reporting and Investigating Child Abuse and Neglect, OPS-913-15*
- G. *Eliminating and Reporting of Sexual Abuse and Harassment, RF-701-18*
- H. *Youth Workplace Violence Reduction Committee, OPS-909-15*

IX. APPENDICES

- 1. Training Document
- 2. Crisis Behavioral Health Referral Form
- 3. Family - Restraint Debriefing Form
- 4. Nursing Report of Youth Injuries Form
- 5. Youth - Restraint Debriefing Form
- 6. Unit - Restraint Debriefing Form
- 7. Staff - Restraint Debriefing Form



DJS Policy and Standard Operating Procedures Statement of Receipt and Acknowledgment of Review

SUBJECT: Restraints - Use of Physical and Mechanical Restraints
NUMBER: RF-718-26
APPLICABLE TO: All DJS Residential Services Employees
EFFECTIVE DATE: March 12, 2026

I have received and reviewed a copy (electronic or paper) of the above titled policy.

I understand that failure to sign this acknowledgment form within five (5) working days of receipt of the policy shall be grounds for disciplinary action up to and including termination of employment.

I understand that I will be held accountable for implementing this policy even if I fail to sign this acknowledgment form.

SIGNATURE

PRINT FULL NAME

DATE

***PLEASE SEND COPIES OF THE SIGNED ACKNOWLEDGMENT FORM
TO YOUR SUPERVISOR AND TO THE OFFICE OF HUMAN
RESOURCES, FOR PLACEMENT IN YOUR PERSONNEL FILE***





Safe Crisis Management® (SCM) Training Guidance

Staff have a total of six (6) chances to pass the theory portion of SCM training (three (3) chances per session) and six (6) chances total to pass the performance portion of SCM (three (3) chances per session).

The standard score for passing is established by JKM Training, Inc. A passing score is 85% on all exams.

- *Safe Crisis Management® Initial* is a 3-Day Training held in Entry Level Training (ELT).
- *Safe Crisis Management® Performance Refresher* is held for six (6) hours with a Performance Checklist (PCL). Testing occurs directly after the completion of the facilitation of the class. There is a PCL for the physical performance test that must be completed as well. Physical performance is a pass or fail completion of all the moves taught by DJS instructors (no prone or supine assists).
- *Safe Crisis Management® Theory Refresher* is held for six (6) hours with a written test at the conclusion of training. A physical test is not a requirement for the theory-only course.
- In cases where the SCM Initial 3-Day Training is taken through in-service training, both the theory test and physical test will be given on the final day of the training.

When does testing occur?

- In ELT, the Theory section of the SCM Initial 3-Day Training test is given on the second day of training. For the SCM Performance section, the test is given on the third day of training.
- In in-service training, SCM Theory Refresher testing occurs upon completion of the facilitation of the training.
- In in-service training, SCM Performance Refresher testing is given and graded directly after completion of the facilitation of the training.

If the employee fails to pass, when can the employee re-test?

- For SCM Initial training in ELT, trainees are able to retest within 24 hours.
- For SCM Refreshers through In-service training, staff can reschedule with their Training Administrator for the next available session in accordance with facility administration approval and work schedule considerations.

How long will it be until they can take the full training again?

- Participants needing to retake the SCM Initial 3-Day Training can join the next Entry Level Training session. PTEU coordinates the scheduling with the facility leadership. Timeframes between the delivery of the SCM course between ELT sessions is approximately four (4) weeks.

If an employee fails to pass due to a medical condition?

If an employee is unable to successfully complete the required assessment due to a medical condition, the following steps shall be taken:

- When applicable, the Department shall inform the employee of their right to request a reasonable accommodation under the Americans with Disabilities Act (ADA) through the Office of Fair Practice and Inclusion.
- The Office of Fair Practice and Inclusion shall assist the employee in submitting an accommodation request and will engage in the interactive process to determine whether a reasonable accommodation can be provided.
- If the employee is unable to meet the required standard even with reasonable accommodation, the Department will provide career counseling and assist the employee in identifying alternative State positions for which they may qualify.

If an employee fails for reasons other than medical?

If an employee is unable to successfully complete the required assessment for reasons not related to a medical condition:

- The Department shall provide career counseling and assist the employee in identifying alternative State positions for which they may qualify.

What if an employee has a temporary medical condition that prevents them from taking and passing the training?

If an employee has a temporary medical condition that prevents them from completing or passing the required training:

- When applicable, the Department shall advise the employee of their right to request a reasonable accommodation under the Americans with Disabilities Act (ADA) through the Office of Fair Practice and Inclusion.
- The Office of Fair Practice and Inclusion shall assist the employee in submitting an accommodation request and will engage in the interactive process to determine whether a reasonable accommodation can be provided.

Current PTEU practice for SCM training and Delivery

Entry Level Training SCM Coaching and Support				
Attempt		1st Failure	2nd Failure	3rd Failure
1st Session	Written Exam	One-on-one review of failed material	One-on-one with employee to review specific areas that were not passed and provide support to reach an 85% Standard	Notify Facility Superintendent/ Assistant Superintendent Schedule 2nd enrollment, if they are within 10% of the 85% Standard Study initial SCM training participant workbook
	Skills Assessment	Verbal coaching of Emergency Safety Physical Interventions not performed to an 85% Standard	One-on-one review with verbal and physical examples of Emergency Safety Physical Interventions not performed to an 85% Standard	Notify Facility Superintendent/ Assistant Superintendent Schedule 2nd enrollment, if they are within 10% of the 85% Standard Study and/or practice with Facility SCM adjunct trainer
2nd Session	Written Exam	One-on-one review of failed material if not passed to an 85% Standard	One-on-one with employee review to review specific areas that were not passed and provide support of failed material	Referral to the Executive Director and HR
	Skills Assessment	Verbal coaching of Emergency Safety Physical Interventions not performed to an 85% Standard	One-on-one review with verbal and physical examples of Emergency Safety Physical Interventions not performed to an 85% Standard	Referral to the Executive Director and HR

In-Service Training SCM Coaching and Support				
Attempt		1st Failure	2nd Failure	3rd Failure
1st Session	Written Exam	One-on-one review of failed material if not passed to an 85% Standard	One-on-one with employee to review specific areas that were not passed and provide support.	Notify Facility Superintendent/ Assistant Superintendent Schedule 2nd enrollment, if they are within 10% of the 85% Standard Study initial SCM training participant workbook
	Skills Assessment	Verbal coaching of Emergency Safety Physical Interventions not performed to an 85% Standard	One-on-one review with verbal and physical examples of Emergency Safety Physical Interventions not performed to an 85% Standard	Notify Facility Superintendent/ Assistant Superintendent Schedule 2nd enrollment, if they are within 10% of the 85% Standard Study and/or practice with facility SCM adjunct trainer
2nd Session	Written Exam	One-on-one review of failed material if not passed to an 85% Standard	One-on-one with employee review to review specific areas that were not passed and provide support of failed material	Referral to the Executive Director and HR
	Skills Performance	Verbal coaching of Emergency Safety Physical Interventions not performed to an 85% Standard	One-on-one review with verbal and physical examples of Emergency Safety Physical Interventions not performed to an 85% Standard	Referral to the Executive Director and HR

CRISIS Behavioral Health Referral Form

Youth's Name: _____		Facility: Select _____	
D.O.B.: _____		Unit/Group: _____	
Shift Commander/Designee Name: _____			
Notification Date: _____		Notification Time: _____ ☐ am ☐ pm ☐ Phone ☐ In Person	
Behavioral Health Clinician's Name: _____		Contacted By: _____	
1. Reason for Notification/Referral (Check all that apply):			
☐ Self-injurious Behavior ☐ Seclusion ☐ Restraint ☐ Homicidal Ideation ☐ Flagged on MAYSI ☐ Suicidal Ideation ☐ Hearing voices, hallucinations ☐ Alleged Sexual Abuse/Contact by youth ☐ Suicide Attempt ☐ Death ☐ Alleged Sexual Abuse/Contact by staff ☐ Substance Abuse Detoxification ☐ Other (<i>Provide explanation below</i>) ☐ Youth on Youth Assault ☐ Youth on Staff Assault			
2. Behavioral Health Clinician's Recommendations, Instructions and/or Comments. (note if any attachments)			
Received from: _____		Date: _____ Time: ☐ am ☐ pm	
Print Name of Behavioral Health Clinician		Shift Commander/Designee: _____	
BEHAVIORAL HEALTH CLINICIAN'S FACE-TO-FACE FOLLOW-UP			
Assessment & Interventions:		Suicide Watch: ☐ Level I ☐ Level II ☐ Discontinued ☐ N/A	
Behavioral Health Clinician: _____		_____	
<i>Print Name</i>		<i>Signature</i>	
Date: _____	Start Time: _____ ☐ am ☐ pm	_____ ☐ am ☐ pm	
Copy:	Living Unit (LU) Principal Youth Health Record	Superintendent Case Manager Supervisor Youth File	Assistant Superintendent Case Manager Shift Commander Medical Department

Debriefing with Family/Guardians	
Youth's Name:	Incident Date and Time:
Parent/Guardian's Name:	
Explain the purpose of the contact, which is to: 1. Notify them of the incident and 2. Invite them to participate in further discussion and planning for the youth.	
Actively listen to any concerns or issues, which were:	
Emphasize the collaborative nature of this process, without communicating blame.	
Describe the conversation.	
Next steps as identified.	
After the meeting:	
Assigned follow-up and assigned completion dates.	
Confirm completion of follow-up.	



Nursing Report of Youth Injuries

(Form must be completed by a RN, LPN, NP, PA or MD)

Date/Time of Incident: ____/____/____ Date/Time Nurse Notified: ____/____/____

Mark location of each injury using the legend below:

- C Contusion
- A Abrasion
- L Laceration
- B Burn
- M Muscle/Bone Injury
- P Puncture

Date/Time Youth Assessed: ____/____/____ Location of Assessment: _____

Assessment limited due to youth refusal: ☐ No ☐ Yes (If Yes, an assessment must still be done)

Circumstances of the assessment if limited: _____

S: What Happened? (Record youth's verbatim response)

Pain Rating by Youth: ☐ 1 to 10, 1 = no pain, 10 = worst possible pain

O: Physical Findings

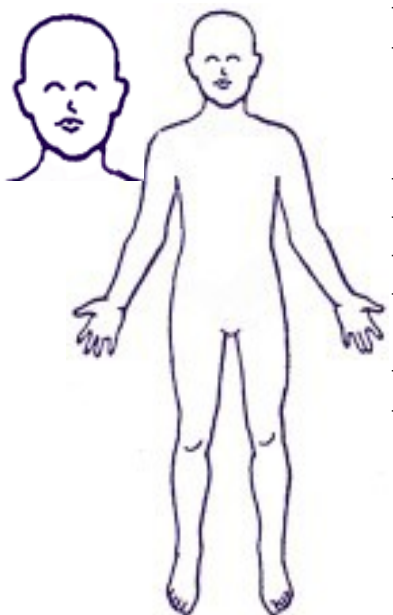
A: Assessment

Injury Severity Rating Scale (0-3): ☐

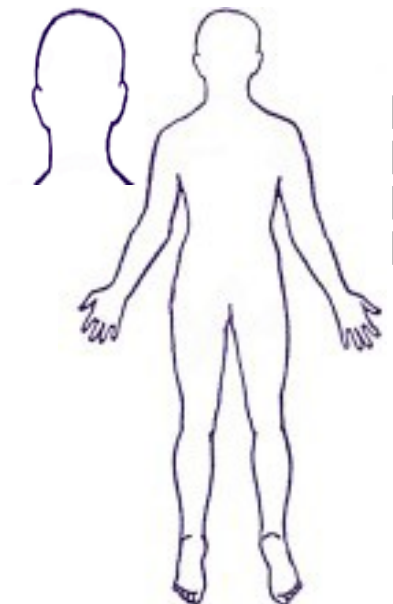
- (0) No visible injury or pain
 - (1) Injury/pain requiring medical care on-site at the DJS facility
 - (2) Injury/pain requiring out-patient care at an ER/medical facility
 - (3) Injury requiring hospitalization at an outside medical facility
- Note: If a youth suffers from two or more injuries from a single incident, the injury severity rating will reflect the most serious injury.

P: Plan (e.g., wound care, bandage, ice, OTC pain med, MD/NP consultation, X-Ray, ER referral, other)

FRONT



BACK



Yes No

☐ ☐ Were photos taken? # of Photos Taken: _____ (Photos must be taken of all injuries & non-injuries)

☐ ☐ Did youth allege abuse occurred? If Yes, report to CPS

☐ ☐ Did youth identify an alleged abuser?

☐ ☐ Do the circumstances indicate the youth may have been abused? If yes, report to CPS

☐ ☐ Was an oral/phone CPS report completed?

(If youth alleged or the circumstances indicate abuse, then the nurse needs to inform the youth of mandated reporting).

If CPS oral report made, completed by:

Name: _____ Date: _____ Time: _____

Name of CPS staff person to whom oral report was given: _____

If oral CPS report was made, must also complete the CPS REPORT OF SUSPECTED CHILD ABUSE/NEGLECT form and submit to CPS within 48 hours.

Person completing this form: _____ Title: _____

Signature: _____ Date: _____ Time: _____

Photos & Original form to be filed in Youth's Health Record. Provide copy of form & photos to the facility Shift Commander for the incident report.

YOUTH NAME: _____ DOB: _____ FACILITY: _____

Debriefing with the Individual Summary

Youth Name:

Incident Date and Time:

Start the debriefing process by asking the youth what happened. Ask about the youth's well-being.

How did the individual describe the incident as they experienced it

Describe how you shared your perception of the incident.

Was this incident connected to a pattern of behavior? Yes/No. If so, how did you discuss this with the youth?

What alternative ways of handling the situation were explored?

What action (SMART) plan was developed to address the identified behavior?

- Specific
- Measurable
- Agreed Upon
- Realistic & Restorative
- Time-Based

Describe the individual's return to programming.

Debriefing with the Unit

Names:

Incident Date and Time:

Does anyone have any concerns or questions about the incident?

Does anyone want to suggest anything we can do to address those concerns?

Explore with the unit how they will keep up STARR behavior when the person returns.

What will that look like?

Debriefing with Staff

Incident Date and Time:

When asked, the staff indicates their physical condition as:

When asked, the staff indicates their emotional condition as:

Assess if staff is able to continue with their responsibilities on the unit. If not, make re-assignment, refer to Behavioral Health or EAP.

Review the incident

What variables may have contributed to the incident?

STAGES OF CRISIS

YOUTH'S BEHAVIOR

STAFF INTERVENTION

PRE-CRISIS

ESCALATION

CRISIS

DE-ESCALATION

What worked and what would you change?

Did you feel supported?

Why, or why not?

What could have improved the situation?

Was the Guarded Care Plan followed, if applicable?

Why or why not?