

Department of Early Education and Care
INTERAGENCY RESTRAINT COORDINATION GROUP

**GUIDELINES FOR BEHAVIOR MANAGEMENT POLICY, PHYSICAL RESTRAINT
POLICY AND
IMPLEMENTATION OF PHYSICAL RESTRAINT**

102 CMR 3.07(7)(a) 3 requires that each licensee maintain a written statement defining the rules, policies and procedures for behavior management. The statement must define and explain the use of behavior management procedures used in the facility, including, where applicable, “the form of restraint used in an emergency, the behavioral interventions used as alternatives to restraint, and controls on abuse of such restraints.” 102 CMR 3.07(7)(j) further defines limits on specific restraint holds and the circumstances under which physical restraint may be applied. Program staff must be trained to follow the guidelines, below, as well as approved program policy at all times.

A program’s policy must include the following components and must adhere to the guidelines and limitations noted below.

1. **Appropriate responses to misbehavior**, including a complete list of both positive and negative responses/consequences used by the program.
2. **Appropriate interventions prior to restraint**, including a description of the agency’s methods of de-escalation of a resident and procedures for preventing the need for a physical restraint.
3. **A description of the circumstances under which restraint may be used, citing specific examples of behaviors which would immediately precede a restraint.** The threshold for use of restraint defined in the regulation is that a resident is demonstrating a danger to self or others and the danger has been or is unlikely to be averted by alternatives to restraint. Staff judgment about the seriousness of the danger in each individual situation is a crucial part of the understanding about whether or not the threshold is reached. No set of examples, however exhaustive, can substitute for the careful judgment of a staff person properly trained in de-escalation and prevention of physical restraint. Staff must be trained to identify demonstrable dangers posed by specific behaviors of the populations served by the program and must, in each instance, be able to justify their decision to use restraint.

Examples of “demonstrable danger” may include but not be limited to the following: a resident is being assaultive, self-injurious, threatening injury with a weapon, a resident attempting to or putting their hand through a window, attempting to use large or broken furniture to injure themselves or others, or inciting a riot where other interventions have been tried and found ineffective and a serious disturbance is imminent. Examples of behaviors which in and of themselves do not reach the threshold of demonstrable danger may include: yelling, swearing, verbal threats, clenching a fist, asking about consequences,

destroying property, banging or pounding with their fist (without injury), or refusing to comply with a rule or staff directive.

4. **The name of the restraint coordinator and the names and positions of staff who serve on the restraint safety committee.** In order to insure that physical restraint in residential programs is afforded effective oversight, licensee must identify one or more staff as a restraint coordinator. Each coordinator will be responsible for oversight and documentation of restraint training; ensuring that restraint is employed only when necessary and is carried out according to the training provided; and collecting restraint and injury data. The program's identified restraint coordinator must review each incident of physical restraint.
5. **A description of the use of physical escort, if applicable.** The description must include examples of behaviors which would immediately precede an escort, and a specific description of how a resident would be escorted, including how many staff participate in the escort, what parts of the child's body are controlled during the escort, the location to which the child will be escorted, and any limitations on escort (such as prohibitions on escorting a child on stairs, in a crowded room, in public, etc.) An escort may not include dragging a resident or carrying a resisting resident, unless the child is of an age and size generally considered appropriate for carrying. Carrying a young child to safety in an appropriate manner would include a situation where the child was too young to completely understand the danger or one who could not walk fast enough to get away from danger, but who would have walked with some guidance/assistance from staff. This situation would be considered an escort. However, a pre-adolescent or adolescent resident who is resisting an escort should first be offered the opportunity to walk on his/her own. The alternative of removing other residents from the area must also be considered and should be employed if possible. If an acting out resident continues to refuse an escort (and the room cannot be cleared of others), and he/she is presenting a demonstrable danger, the resident may require a physical restraint instead of an escort. As noted in the definition of escort, in section 3.02, when a resident, who is larger than the size where carrying is normally appropriate, must be carried due to a demonstrable danger, that intervention must be considered a restraint. In such a circumstance, the program must develop and teach safe appropriate carry techniques to staff and must clarify that these carry techniques constitute a physical restraint.
6. **A complete description of the method of physical take-down, for restraints other than standing restraint.** The description must identify how many staff are involved in the takedown, the steps of the takedown (if children are moved to preliminary positions prior to lying or sitting on the floor) and whether the child is taken to a sitting, prone or supine position. Staff may not manipulate a resident's head or neck to move the resident from a standing to a seated or floor position. Methods of moving a resident from a standing to a horizontal position which allow the resident's chest or back to strike the floor before the knees, arms or buttocks, may damage the breathing apparatus and are prohibited. A program's guidelines must specify that staff are to initially attempt the least restrictive position available to them within their program's approved method unless immediate safety concerns dictate otherwise. Typically staff should initiate a standing restraint and only progress to more restrictive positions, such as a sitting or floor restraint, if the standing hold is not sufficient to provide safety for the resident or others. Program policy must specify

the conditions which would justify staff deciding to implement a progressively more restrictive hold.

7. **The name of the method of physical restraint employed, and a complete description of each type of hold used**, including the number of staff involved, how the staff are deployed during the hold, the specific parts of the body which staff are assigned to restrain, the placement of the child's head and limbs during the hold, and the placement of all staff involved in the hold. As noted in the memo issued by Secretary O'Leary in May 1998, under no circumstances are headlocks, choke holds, full or half nelsons, or pressure points to cause pain be used. No holds which cover any portion of the face or use any cloth or object on the face are permitted. No hold which puts a resident in the "hog-tied" position is permitted. Prone restraints should never take place on soft surfaces such as mattresses, which could impair breathing. Holds which include any direct force or pressure on the chest or diaphragm may restrict breathing and are therefore prohibited. The hold commonly described as a "prone basket", in which the resident is lying face down with his/her arms or hands underneath any part of the chest, may restrict breathing, and is prohibited. A straddle position may not be used for any resident with a history of sexual abuse. Holds which require the resident's hands to be held behind the back must be justified by the physical threat presented by the population the program serves.

Regulation 3.07(7)(a) requires programs to develop and submit their policies and procedures on controls on abuse of restraint; such policies and procedures must address what steps staff may and may not take when an escort or restraint goes awry; i.e. if staff are unable to obtain or maintain the escort or restraint hold as taught. Each program must develop appropriate guidelines for how staff may intervene, according to the principle of utilizing the least intrusive means necessary to keep the resident and others safe.

8. **Guidelines for monitoring the resident and release of the restraint.** Describe how your staff monitor physical restraint and how they respond to distress. In general, monitoring may be accomplished by visual, tactile, and/or verbal means. A method of monitoring which combines more than one sensory channel provides greater safety. **The often used statement "if she/he can talk, he/she can breathe" is false;** staff must be trained not to rely on the fact that a resident is able to speak as evidence of absence of distress. Monitoring the resident during a standing hold may include use of one or more of the sensory channels, in accordance with the population's developmental abilities. For verbal residents, staff must be trained to assess both the content and quality of a resident's verbal responses. Monitoring the resident during any sitting or floor position must be accomplished by staff being able to visually observe the resident's condition and the breathing; that is, **staff must be able to look at the resident's face.** Visual monitoring may be done by staff who are participating in the restraint, as long as the program's approved sitting or floor position allows for staff involved in the restraint to see the resident's face. Finally, guidelines should also indicate who is responsible for approving any restraint which lasts longer than 20 minutes, and the circumstances under which such continuation would be approved. It's clear that the length of the restraint is directly connected to an increase in the rate of injury in many children. Therefore, the goal of each physical intervention should be that it is discontinued as soon as possible. The expectation of the

Interagency Group is that restraints which last more than 20 minutes should be a rarity. Staff should be trained to continually seek assistance of other staff, clinicians and administrators regarding a restraint which continues for a lengthy period of time. Staff should consider “switching off” not only to relieve their own fatigue but to offer the resident an alternative person to assist with de-escalation and ending the restraint.

Guidelines and procedures for release from the restraint must be described. As noted by the regulation, a resident must be released at the first indication of safety **or** upon appearance of any significant physical distress. In general, breathing patterns should change, over the course of a restraint, from faster to slower and more regular. A breathing pattern which changes after initially calming is a sign of significant distress and requires immediate release. A statement of breathing difficulty, labored breathing, rapid breathing, “grunting” sounds, sudden silence or indication of vomiting are some, but not all, of other signs of significant distress. **These signs must be taken seriously and require immediate release and an assessment of the need for further medical attention.** Residents may express some mild discomfort in their extremities during a restraint; staff should always respond by initiating a partial release or adjusting their hold. Staff must always be aware that a physical restraint is a physiological intervention as well as a behavioral one. Staff should always evaluate a resident’s response in the context of emotional/behavioral **and** physical distress.

9. **Processing and Follow-up.** A complete description of the program’s procedures for processing a restraint with a resident and the follow-up and quality assurance procedures used with staff must be submitted.
10. **Documentation procedures.** All restraints must be documented in a physical restraint incident report. A copy of the program’s restraint incident report form and any other restraint documentation forms and procedures used by the program must be submitted.
11. **A complete description of the training which will be provided for staff prior to their participation in restraint.** The description must include the qualifications of the trainer, the method of training, the training curriculum and the number of hours involved in the training. The training plan must specify the requirements for refresher training. A copy of the agency’s restraint training schedule must be submitted.