City of New York
Administration for Children's Services

Policy and Procedure
#2016/09

Safe Intervention Policy for the Children's Center

Approved By: Gladys Carrión, Esq. Commissioner	**Date Issued:** 10/7/2016	**Number of Pages:** 15	**Number of Attachments:** 3
Related Laws: Soc. Serv. Law §§ 20, 34, 153, 358-a, 373-a, 374-b, 384-b, 387, 398, 398-a, 409-f, 427, 442, 462, 490, Articles 6, 10, and 10-c of the Family Court Act	**ACS Divisions/Provider Agency:** Family Permanency Services (FPS)	**Contact Office /Unit:** Duandie Martinez Executive Director of Operations Duandie.Martinez@acs.nyc.gov	
Supporting Regulations: 14 NYCRR §§ 704.5-704.7, 18 NYCRR § 441.17, 18 NYCRR § 442.2	**Supporting Case Law:** NA	**Keywords:** acute physical behavior, Children's Center, crisis intervention system, debriefing, de-escalation, manager's summary, physical intervention, restraint, Safe Crisis Management, SCM, Therapeutic Crisis Intervention, TCI, Care Plan	
Bulletins & Directives: NA	**Related Policies:** • Reporting of Incidents Policy at the Children's Center • Supervision of Children Policy at the Children's Center	**Supersedes:** NA	

Related Forms:

A. Post Physical Restraint Health Report
B. Staff Debriefing Report
C. Youth Debriefing Report

SUMMARY:
This policy articulates guidelines and procedures for staff when addressing the acute physical behavior of children who are in the care and custody, custody and guardianship, or care and maintenance of the Administration for Children's Services (ACS) at the Nicholas Scoppetta Children's Center. It is ACS's policy that staff must use the least restrictive intervention necessary to control a child's acute physical behavior. To accomplish this, staff members are expected to receive training in and employ the use of Safe Crisis Management (SCM), a crisis intervention system which will emphasize prevention, non-physical interventions, and the use of physical intervention only for emergencies or as a last resort. ACS will not tolerate the use of excessive force or inappropriate physical intervention techniques.

SCOPE:
The policy applies to children at the Nicholas Scoppetta Children's Center, who are in the custody, care and custody, custody and guardianship, or care and maintenance of the Commissioner of ACS.

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I. Purpose

The purpose of this policy is to provide clear guidelines and procedures for staff to follow when they are required to contain the acute physical behavior of children who are in the care and custody, custody and guardianship, or care and maintenance of the Administration for Children's Services (ACS) at the Nicholas Scoppetta Children's Center (hereinafter "Children's Center"). This policy requires a comprehensive continuum of strategies for prevention, de-escalation, and physical intervention during emergencies to respond to acute physical behavior. The primary purpose of any physical intervention shall be to protect the safety of the children involved in the incident and all other children, the staff, the community, and others who may be present, within a context that promotes healthy relationships with children, including employing effective communication, making empathetic connections, and establishing a structured, consistent environment. ACS will not tolerate the use of excessive force or inappropriate physical intervention techniques.

II. Definitions

A. Active Listening – A communication technique, which requires the listener to identify and express what he or she hears to the speaker by way of reflecting on or paraphrasing what he or she has heard, in his or her own words, to confirm what the listener has heard and to confirm the understanding of both parties. Active listening is a communication technique that conveys care and respect to the speaker. There is no arguing or premature problem-solving involved.

B. Acute Physical Behavior – Behavior which clearly indicates the intent to inflict physical injury upon oneself or others or to otherwise jeopardize the safety of any person.

C. The Care Plan – A plan developed by the Child Care Team (CCT) in collaboration with medical staff and other key actors and addresses the mental health, behavioral, and/or other clinical issues that are present, and the preferred intervention strategies to be used to de-escalate the child's behavior(s). The care plan will include any limitation or prohibition on the use of physical intervention for the child based on either medical or therapeutic grounds. The Care Plan will be updated as needed and shared with all relevant child care staff who regularly interact with the child.

D. Debriefing – A structured process, used after an emergency physical intervention, when the child is calm. During the debriefing, staff will review the incident with the child to determine the well-being of the child, to review the behavior that led to the physical intervention, to teach new coping skills or behavior, and to return the child to the program or routine.

E. De-escalation – A non-physical, pro-active prevention strategy for management of acute physical behavior. Any verbal or non-verbal intervention that contributes to effective

communication, problem-solving, prevention of power struggles, or conflict resolution aimed at calming a potentially volatile situation and avoiding any physical intervention.

F. Least Restrictive Alternative – The least amount of intervention necessary to manage a child's acute physical behavior.

G. Mechanical Restraint – For purposes of this policy, a restraining device, which may consist only of handcuffs, used to contain acute physical behavior during transport. For purposes of this policy, the use of footcuffs is expressly prohibited.

H. Para-verbal Intervention – Interventions transmitted through the tone, pitch, and pacing of staff members' voices. In other words, the message(s) that staff members convey to a child by how staff members say something rather than what staff members are saying.

I. Physical Intervention – The use of trained staff members to physically hold or move a child in order to contain acute physical behavior. The use of physical intervention cannot be used to assert authority, enforce compliance, inflict harm, punish a child, or be used at the convenience of staff.

J. Pre-Placement Summary – An electronic summary prepared by the lead manager or supervisor on duty at the end of every shift change. A Pre-Placement Summary includes the youth census, special alerts, AWOL notification, scheduled appointments, staffing pattern, and information regarding any safe interventions that occurred during that particular shift. This summary is prepared prior to the end of each shift. The summary is shared with senior leadership and others who are responsible for the care of children at the Children's Center.

K. Safe Crisis Management (SCM) – A comprehensive crisis intervention and behavior management system that emphasizes de-escalation, includes guidance for prevention strategies, non-physical intervention, emergency safety physical intervention (ESPI), after-incident resolution, and follow-up.

L. Unit Log – A permanent and official record of events, incidents, and observations surrounding the care and supervision of children while on the unit.

III. Policy

A. It is ACS' policy to promote the safety of children and staff at the Children's Center using the least restrictive intervention necessary. The approach used requires a continuum of strategies to address acute physical behavior. Appropriately trained staff shall make best efforts to address a child's acute physical behavior by using preventive and de-escalation techniques. Trained staff shall only use authorized physical interventions as a last resort, or

during an emergency, after other forms of intervention have been or are likely to be ineffective.[1]

B. Physical interventions shall only be used when:[2]

1. The child is at imminent risk of causing physical harm to himself or herself;
2. The child is at imminent risk of causing physical harm to other children, staff, or others present; and/or
3. The child is destroying property which is creating imminent risk of physical harm to himself or herself or to others.

C. Where the use of an authorized physical intervention is necessary, appropriately trained staff shall only use the minimum amount of force necessary to stabilize the child or situation. Staff must stop the authorized physical intervention as soon as the threat to safety has ceased. Disciplinary and/or other corrective action, such as a report to the Justice Center for the Protection of People with Special Needs / Vulnerable Person's Central Register (VPCR), can occur as a result of any failure to use de-escalation techniques where there is an opportunity to do so, failure to make efforts to protect a child or staff from harm due to assaultive or violent behavior, and failure to make efforts to protect children from self-inflicted injury.

D. ACS Police shall only use mechanical restraints for the pre-approved limited purpose of transporting a child in a vehicle when the child constitutes a clear danger to public safety, or to him/herself. Prior to applying mechanical restraints to a child, such use of mechanical restraints must be authorized by the Children's Center's Executive Director of Operations. Staff is otherwise prohibited from using a restraining device or mechanical restraints at any time in order to contain a child's acute physical behavior.

E. A physical intervention must never be used for punishment or for the convenience of staff.[3]

IV. Staff Training

A. All staff responsible for the care and custody of children, including ACS Police and nursing staff, shall receive all training required by SCM and ACS. New employees responsible for the custody and care of children may not work with children until they have successfully completed the initial SCM training.[4] All employees responsible for the care and custody of children, as well as ACS Police, must demonstrate competency in SCM prior to working with children and must successfully complete refresher training every six (6) months as

[1] 18 NYCRR § 441.17(b)
[2] 18 NYCRR § 441.17(a)
[3] 18 NYCRR § 441.17(b)
[4] 18 NYCRR § 441.17(h)

prescribed by ACS and approved by OCFS.[5] Training will include, but not be limited to, the following:[6]

1. The alignment of SCM to ACS's mission, including the importance of program structure and routine, relationship-building with all children, and the use of positive behavior support in preventing problematic behavior.

2. Preventive methods and procedures for situations that might lead to the use of physical interventions and appropriate alternatives to physical interventions, including the use of non-verbal and verbal de-escalation techniques to reduce agitation in children. Also, methods for evaluating the risk of harm in situations to determine if physical interventions should be employed.

3. Methods of applying physical interventions, the rules that must be observed in doing so, and circumstances when physical interventions may be necessary. The training must include simulation of administering and reviewing physical intervention techniques.

4. The effects of physical interventions on the person being held, the specific risks associated with physical interventions,[7] as well as instruction on monitoring distress indicators and seeking medical assistance.

5. Documentation and reporting requirements, and investigation of injuries and complaints.

6. Competency testing for the use of physical interventions.

7. CPR certification and first aid training.

8. Proper completion of the Unit Log.

V. Preventing and De-escalating a Child's Acute Physical Behavior[8]

A. If and when a child is exhibiting acute physical behavior, appropriately trained staff members must make best efforts to use the skills and strategies acquired from their SCM training to de-escalate the child's acute physical behavior without using any physical intervention. It is crucial for staff members to exercise self-control over their feelings and to actively listen to the child, who is exhibiting acute physical behavior, in order to de-escalate any crisis.

[5] 18 NYCRR § 441.17(h)
[6] 18 NYCRR § 441.17(h)
[7] 18 NYCRR § 441.17(b)
[8] 18 NYCRR § 441.17(b)

B. Appropriately trained staff members are generally expected to successfully de-escalate a child's acute physical behavior without using physical intervention. Staff members must only use physical intervention as a last resort after de-escalation skills and strategies are proven unsuccessful.[9] Section VI below provides guidance on the proper administration of physical interventions.

C. If/when a child is demonstrating behavior(s) that raise(s) immediate serious concern for the safety of the child or others, appropriately trained staff members can make an immediate physical intervention on an emergency basis, without the prior use of de-escalation skills and strategies.[10] Section VI below provides guidance on the proper administration of physical interventions.

VI. Proper Administration of Physical Interventions[11]

A. De-escalation techniques without the use of physical interventions will almost always be the first response when a child demonstrates behaviors of concern. However, there may be situations where all reasonable and appropriate de-escalation techniques have been exhausted or a child is demonstrating behavior(s) that raise immediate serious concern for the safety of the child or others. In such instances, an immediate physical intervention, without the prior use of de-escalation techniques, is the necessary course of action. If a physical intervention is administered without prior attempts to de-escalate the situation or contrary to the child's Care Plan, the staff involved in the incident must document the extenuating circumstances that led to a physical intervention in the incident report narrative.[12]

B. ACS authorizes the use of a continuum of physical interventions ranging from least restrictive and least likely to cause harm to more restrictive physical interventions. All physical interventions must use techniques sanctioned by ACS, taught by qualified SCM instructors, appropriate to the level of risk presented by the child, using the least amount of force necessary to stabilize the child or situation, and sanctioned by the child's Care Plan, if applicable.[13] Staff shall apply the minimum amount of force that stabilizes the child and situation, and reduce the level of force as the child and situation stabilize.[14]

C. It is strongly preferred that any physical intervention is administered by multiple staff. In order to protect the safety of both staff and children, single-staff intervention shall only

[9] 18 NYCRR § 441.17(b)
[10] 18 NYCRR § 441.17(b), (h)
[11] 18 NYCRR § 441.17(b)
[12] See Reporting of Incidents Policy at the Children's Center.
[13] 18 NYCRR § 441.17(c)
[14] 18 NYCRR § 441.17(b)

be used under emergency circumstances where other staff persons have been called for assistance, if possible.[15]

D. During the administration of a physical intervention, staff must monitor the child for distress symptoms. Supervisors on scene or designated shift leaders shall assume this function or assign staff, as appropriate.

E. The duration of a physical intervention is a critical element regarding child and staff safety. A physical intervention shall terminate as soon as possible and must end as soon as the threat has ceased.[16]

F. A physical intervention shall not persist longer than 10 minutes. Physical interventions exceeding 10 minutes require administrative approval to continue the physical intervention. In situations where staff is unavailable to seek administrative approval, the Manager on Call or Executive Director of Operations shall be notified for approval beyond 10 minutes, when it is safe to do so. The use of a physical intervention exceeding 10 minutes must be specifically documented in the Unit Log with an explanation for the duration of the intervention.

G. Staff providing physical intervention must monitor and govern their emotions. Professional interventions delivered in a calm emotional state are required.

H. Any staff witnessing a colleague becoming agitated during an intervention is required to signal the colleague to remove him/herself from the situation and permit other staff to take over.

I. Children who are not involved in an incident shall be directed away from, and, if necessary, removed from the incident site as soon as practicable. Such removal shall end as soon as the circumstances that led to the removal are under control.

J. During a physical intervention, once a child has regained control of him/herself to the point where the child can be moved, the child shall be taken to an area away from the site of the incident in order to contain the incident. The purpose of this move is not to confine, but to contain the situation. Staff may choose to escort the child to a counseling area, if appropriate.

K. Staff shall constantly monitor a child's responsiveness during a physical intervention. Medical emergencies shall always override the physical intervention and require staff to call for medical assistance.

[15] 18 NYCRR § 441.17(c)
[16] 18 NYCRR § 441.17(b)

1. Throughout a physical intervention, staff shall continually monitor whether a child is breathing, is responsive, and can speak. If a child shows signs of difficulty in breathing, staff shall immediately stop the physical intervention.

2. Whenever a child complains that he or she cannot breathe, staff must immediately stop the physical intervention.

3. If breathing is or appears to be absent, if a child appears to have lost consciousness, or if signs of any other health emergencies are evident, staff must immediately stop the physical intervention, call 911, and immediately initiate CPR, including the use of defibrillation, if necessary, until a medical team arrives on the scene.

4. If a child vomits, staff shall immediately release the child from the physical intervention and either sit the child up or help the child to his or her side.

L. A staff member's failure to act when circumstances require staff intervention pursuant to this policy may subject the staff member and agency to investigation and action by OCFS, the VPCR, and/or ACS.

VII. Physical Interventions on Children with Medical/Mental Health Conditions

A. Special precaution shall be used when applying physical interventions on children with medical or mental health conditions, including, but not limited to, children who are pregnant, have respiratory or cardiac problems, are considered obese by a medical practitioner, or are at risk of psychological distress as described in their Care Plan.

B. Staff shall be familiar with the contents of all Care Plans and special needs reports regarding children with medical or mental health conditions. A special needs report shall be included in each child's Care Plan and shall be reviewed prior to each shift's start. The child's name and special need/medical issue shall also be annotated and highlighted in the Pre-Placement Summary.

C. Therapeutic restrictions on the use of physical interventions may be articulated in the child's Care Plan in order to prevent heightened risk of psychological distress. If the child's Care Plan limits or prohibits the use of physical intervention, staff members must follow the child's Care Plan.

D. Staff members must use special precaution when applying physical interventions on children whose growth plates have not been fully developed (usually children 12 years old or younger).

VIII. Prohibited Use of Physical Interventions

A. Physical interventions using any of the following techniques are not permitted under any circumstances and no exception to policy for their use shall be granted:

1. Any physical intervention that uses pressure points on the child;

2. Obstruction of the child's airway and/or excessive pressure on the chest, lungs, sternum, or diaphragm;

3. Hyperextension (pushing or pulling limbs, joints, fingers, thumbs, or neck, beyond normal limits, in any direction) or putting the child in significant risk of hyperextension;

4. Joint or skin torsion (twisting/turning in opposite directions);

5. Direct physical contact covering the face;

6. Straddling or sitting on the child's torso or back;

7. Excessive force (e.g., using more force than is necessary; beyond resisting with like force);

8. Any maneuver that involves punching, hitting, slapping, poking, pinching, or shoving the child;

9. Prone restraint; or

10. The use of restraining devices or mechanical restraints on the child's wrists, arms, legs, or torso, other than the use of mechanical restraints only as defined in Section II. G. and as described in Section III. D.

IX. Post-Physical Intervention Process

A. The Child and Family Specialist (CFS), social worker, or designee is responsible for initiating the post-physical intervention protocol or process within two (2) hours following a physical intervention. The CFS, social worker, or designee must complete the process within 24 hours of the incident.

B. Trained staff must immediately administer first aid, if required, following the application of a physical intervention. If a child or staff member appears or claims to be injured, medical assistance shall be obtained promptly.[17]

[17] 18 NYCRR § 441.17(i)

C. All staff must take steps to have any child seen immediately by medical staff after a physical intervention, whether the child is injured or not.

D. Nursing or medical staff shall take photographs of any child, who was involved in a physical intervention, within one (1) hour of the incident, to document the child's injuries or lack thereof. Photographs are subject to the following rules:

1. Photographs shall be taken with a digital camera.

2. Staff who participated in the physical intervention may not be responsible for taking the photographs.

3. Two (2) frontal full-body photographs of the child -- fully clothed -- shall be taken. Additionally, if the child is injured or purports to have been injured, then two (2) close-up photographs must be taken of each view of a child's injury or purported injury.

4. All photographs must clearly depict actual injuries or purported injury sites.

5. Two (2) copies of each photograph will be printed. Every photograph will be labeled with the following information:

    a. The name of the child photographed;

    b. The date and time of the photograph;

    c. The date and time of the incident;

    d. The name, title, and signature of the person who took the photograph; and

    e. The signature of the child photographed.

6. One (1) full set of photographs shall be submitted with the incident report; the second set shall be filed in the child's medical record.

E. The CFS, social worker, or designee leading the post-physical intervention review must report the physical intervention to the child's parent or guardian as soon as possible, but under no circumstances more than eight (8) hours after its occurrence. If the parent cannot be reached, staff shall continue efforts to make contact and must note such efforts in the Incident Report form.

F. Medical staff shall complete the following actions below:

1. Medical staff on-site shall speak to the child and make a head-to-toe review of the child's physical condition.

2. Medical staff on site shall refer the child to see a physician or hospital for further assessment or treatment, if necessary.

G. Medical staff on site shall complete the *Health Review* portion of the *Post Physical Restraint Health Report* form (see Appendix A) immediately following an examination of the child.

1. If a child refuses a post-physical intervention medical assessment, medical staff on site shall notify the CFS, social worker, or designee. The CFS, social worker, or designee (who was not involved in the physical intervention) can serve as a witness to verify that the child refused the post-physical intervention medical assessment.

2. Medical staff shall then file *the Post Physical Restraint Health Report* in the child's medical chart and forward a copy to the Executive Director of Operations. The Medical Summary Report shall be attached to the Incident Report[18] and filed in the child's case record, as well as the facility incident file.

3. A medical staff member shall call a report into the VPCR[19] if he or she suspects the improper use of a physical intervention on any child.

H. The CFS, social worker, or designee shall complete the remainder of the *Post Physical Restraint Health Report* form (see Appendix A) and document the information in Connections (CNNX).

I. The CFS, social worker, or designee shall conduct a mental health assessment of the child and generate a mental health referral, if necessary. If a child has a history of mental illness or behavioral concerns documented in his or her Care Plan, the CFS, social worker, or designee shall refer the child to a qualified mental health professional as soon as possible after a physical intervention with the child.

J. If a child refuses to participate in a mental health assessment, such refusal must be documented in the child's medical file, in the manager's summary, and in CNNX by the CFS.

K. Following each incident involving a physical intervention, the child and staff involved will have a debriefing conversation when the child is calm, when the incident report is completed, and within 24 hours of the incident.[20] The debriefing conversation will be an effort to discuss behavior(s) of concern, agree upon a plan for future behavior, and return the child to the

[18] See Reporting of Incidents Policy at the Children's Center.
[19] See Reporting of Incidents Policy at the Children's Center.
[20] 18 NYCRR § 441.17(j)

program or routine. The staff member(s) involved in the physical intervention shall not facilitate the debriefing, but shall play an active role.

L. The debriefing conversation will occur in a private and quiet location. The involved individuals should be in control of their emotions, and the debriefing conversation must be conducted calmly.

M. The child and staff involved in a physical intervention shall complete debriefing forms (See Appendix C and D),[21] which the CFS, social worker, or designee will collect.

X. Communication/Reports/Records

A. Any use of a physical intervention with a child shall be reported to the supervisor in charge as soon as the situation is under control. The supervisor in charge shall contact the Executive Director of Operations with details regarding the incident leading to the use of physical intervention.

B. Each employee involved in or witnessing the physical intervention shall complete an Incident Report form as soon as possible following the incident.[22] The supervisor in charge at the time of the physical intervention shall document the occurrence of the physical intervention in the Pre-Placement Summary. Staff on duty shall document the occurrence of the physical intervention in the Unit Log.

C. Any incident of suspected child abuse, unauthorized, or improper use of physical intervention shall be reported to the VPCR.[23]

D. The Children's Center shall maintain daily records of the number of children on whom physical interventions have been used:[24]

1. Name and age of the child involved in the physical intervention;

2. Name(s) of staff involved in the physical intervention;

3. Date and time of the physical intervention;

4. Specific location where the physical intervention occurred;

5. The circumstances or specific behaviors that led to the use of physical intervention, including efforts made to identify and resolve the problem that led to the use of the

[21] 18 NYCRR § 441.17(j)
[22] See Reporting of Incidents Policy at the Children's Center.
[23] See Reporting of Incidents Policy at the Children's Center.
[24] 18 NYCRR § 441.17(k)

physical intervention, the reason physical intervention was determined necessary, and the child's reaction to the use of physical intervention;

6. The specific type of physical intervention used;

7. The length of time each physical intervention was used;

8. Any injuries resulting from the physical intervention; and

9. A description of any debriefing session with the child involved in the physical intervention.

E. Notification to Parents/Guardians

During the post-physical intervention review, the responsible staff member will inform a child's parent/guardian whenever the child has been involved in a physical intervention and shall document such notification. Such notification shall occur immediately and no later than eight (8) hours from the time of the incident.

F. Monitoring Physical Interventions/Evaluation

1. ACS shall have an Incident Review Committee as required by the Justice Center for the Protection of People with Special Needs.[20]

2. ACS shall conduct its own administrative review of the use of physical interventions in the Children's Center as follows:

   a. Read all incident reports involving the use of physical interventions in the Children's Center as soon as possible and, in any case, within 24 hours of occurrence;

   b. Review video footage, as necessary, including when discrepancies exist in reports about the circumstances surrounding an incident, where serious injury results from an incident, or when an incident leads to an allegation of child abuse;

   c. Follow up with involved staff and children when there appear to be issues of concern;

   d. Create a reporting evaluation system based on data that looks at the following:
      i. Frequency of incidents and physical interventions;

      ii. Days, time of day, location, and during which program activities physical interventions were used;

[20] 14 NYCRR § 704.5-704.7; Soc. Serv. Law § 490.

iii. Duration of each physical intervention;

iv. Specific children involved and their frequency of involvement;

v. If children involved in physical interventions are on medication or if they are refusing to take medication as prescribed;

vi. Activities cancelled or denied due to acting-out behavior;

vii. If staff members were aware of and correctly implemented the child's Care Plan, if applicable;

viii. If the Care Plan, if applicable, helped to prevent the use of physical intervention;

ix. Specific staff members involved and their frequency of involvement;

x. Injuries to children and/or staff;

xi. Amount of lost work time;

xii. Frequency of abuse allegations resulting from the use of a physical intervention and calls to the VPCR; and

xiii. Substantiations of abuse allegations or improper or inappropriate use of physical intervention.

NYC ACS

NICHOLAS SCOPPETTA CHILDREN'S CENTER (NSCC)

POST PHYSICAL INTERVENTION HEALTH REPORT

INCIDENT INFORMATION (Please Print) (To be completed by designated facility/community office employee)		
YOUTH'S NAME:	DOB	
DATE OF INCIDENT: / /	SPECIFIC PHOTOS TAKEN	TIME OF INCIDENT ☐am ☐pm
LOCATION OF INCIDENT:		
Incident Report form Attached? ☐YES ☐NO		

STAFF OBSERVATIONS:

Youth's Appearance/Mood:
Youth's Injuries/Physical Complaint(s):

FIRST AID

Was First Aid Needed? ☐YES ☐NO (If YES, date and time administered)	Date / /	Time ☒am ☐pm
If YES, describe:		
Who Administered the First Aid? (Print Name)		
Did the youth lose consciousness during the restraint? ☐NO ☐YES	If YES, for how long?	
What was done to assess or assist the youth during that time?		
NAME OF STAFF COMPLETING REPORT(PLEASE PRINT):	SIGNATURE OF STAFF COMPLETING REPORT:	
DATE:	TIME: ☐AM ☐PM	
HEALTH REVIEW (Please Print((To be completed by Health Staff)		
REVIEW REQUESTED BY:	YOUTH ACCOMPANIED BY:	
ASK YOUTH THE FOLLOWING QUESTIONS AND FILL IN YOUTH'S RESPONSE IN THE SPACE PROVIDED:		

cc: facility restraint file
Medical File (Original)

NYC ACS

NICHOLAS SCOPPETTA CHILDREN'S CENTER (NSCC)

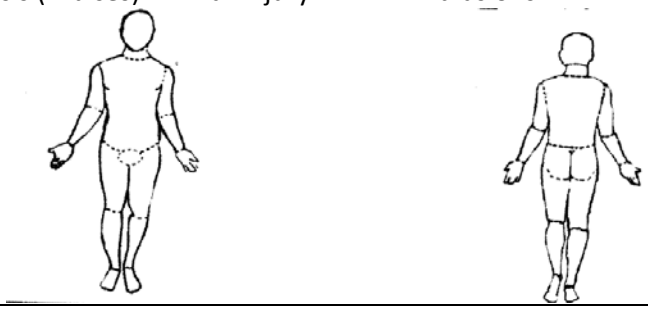
POST PHYSICAL INTERVENTION HEALTH REPORT

Do you have any injuries or pain? ☐ NO ☐YES (If YES explain)

How did you get this injury? (Concentrate on getting youth's description of the occurrence or the mechanics of the physical restraint, not the reasons for the restraint.)

Review by Health Services Staff (Review must include comments on youth complaint(s) on injury or pain and results of a head to toe review of youth's physical condition. Please use arrow(s) to designate location of each injury and note size description of the injury. In addition, place a check mark beside all items that apply)

☐Lacerations ☐Edema(swelling) ☐Eye Injury ☐Oral/Dental Injury ☐Dislocation/Fracture
☐Contusions ☐Ecchymosisi(Bruises) ☐Ear Injury ☐Abrasions ☐Other



Health Services Action Plan/Comments

MD Referral? ☐YES ☐NO Hospital Referral? ☐YES ☐NO

Note: If an injury is inconsistent with nature of incident and restraint, if the restraint appears to have been inappropriately initiated or executed, or if the youth alleges inappropriate staff conduct, the Health Staff must cause a report to be made to the VPCR (Justice Center) and notify the Director or designee.

Director/Designee notified? ☐YES ☐NO If Yes, name of Director/Designee contacted: _____ Date: / / ☐am ☐pm	VPCR (Justice Center) contacted? ☐YES ☐NO VPCR Incident # Date: / / ☐am ☐pm
Name of Health Staff Completing Report (Please Print):	Signature of Health Staff Completing Report:
Name of Youth Reviewed:	Signature of Youth Reviewed
Date: / /	Time: ☐am ☐pm

cc: facility restraint file
Medical File (Original)

NYC ACS

NICHOLAS SCOPPETTA CHILDREN'S CENTER (NSCC)

USE OF PHYSICAL INTERVENTION STAFF DEBRIEFING REPORT

To be completed by administrative staff conducting the debriefing

FACILITY NAME **NSCC**	LOCATION OF INCIDENT:	DATE OF INCIDENT:	TIME OF INCIDENT:
NAME OF YOUTH:		DOB	

Names of Staff Being Debriefed	Title

1. Assessment of Staff's physical and mental well-being (*ask all staff how they are doing, see that injured staff have received medical attention, refer staff to EAP if appropriate*).

2. Youth's behavior prior to restraint:

3. Individual intervention Plan de-escalation techniques used prior to restraint:

4. Effectiveness of interventions:

5. Policy justification for restraint (Injury to self/injury to others):

6. Physical Intervention(s) utilized:

Cc: Facility restraint file
Medical File (original)

NYC ACS

NICHOLAS SCOPPETTA CHILDREN'S CENTER (NSCC)

USE OF PHYSICAL INTERVENTION STAFF DEBRIEFING REPORT

7. If the youth sustained injuries during the restraint, what factors contributed?
What follow-up is needed to return to pre-crisis stability? ☐ Physical Plant Remediation ☐Conflict Resolution ☐ Individual Counseling ☐ Group Session ☐Mental Health Referral ☐ Other
Explain:
8. Suggestions for Improvement to Avoid Recurrence:
9. Comments and Recommendations:
Youth/Child Signature:

Name and Title of Debriefer (Print):	Signature:
DATE COMPLETED: / /	TIME COMPLETED: AM ☐PM

Cc: Facility restraint file
Medical File (original)

NYC ACS

NICHOLAS SCOPPETTA CHILDREN'S CENTER

YOUTH DEBRIEFING REPORT

To be completed by staff conducting the debriefing			
FACILITY NAME **NSCC**	LOCATION OF INCIDENT:	DATE OF INCIDENT:	TIME OF INCIDENT:
NAME OF YOUTH:		DOB:	

Youth Mood and Demeanor

How are you feeling now?
1a. Staff observations of youth mood and demeanor:

Review of Behavior Chain Analysis

What were you upset about?
Is there anything you could have done differently?
What could you do differently in the future? What skills might you use?
What did staff do that was helpful?
Is there anything staff could have done differently?
What needs to be done in order for you to return to program safely?

Name and Title of Debriefer (Print):	Signature:
DATE COMPLETED / /	TIME COMPLETED ☐AM ☐PM

cc: facility restraint file
Medical File (Original)