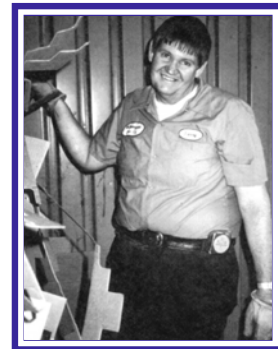
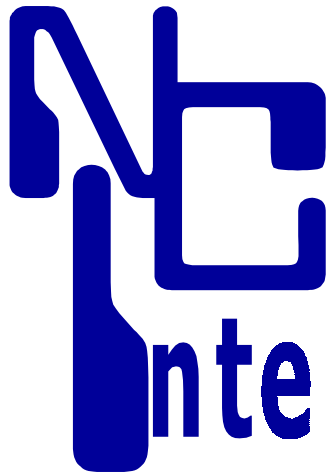


North Carolina

Division of Mental Health, Developmental Disabilities and Substance Abuse



Interventions[®]

Optional Physical Techniques Participant Workbook

2003

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OPTIONAL TECHNIQUES

The following techniques are optional techniques that may be added to the North Carolina Interventions core curriculum based on the needs of the people being served by a facility. Human rights/client rights committee approval is required for inclusion of any optional technique.

Steps indicated with an asterick (*) are considered critical to the safe execution of the technique. Trainees must demonstrate the technique as described in order to be considered competent in that technique.



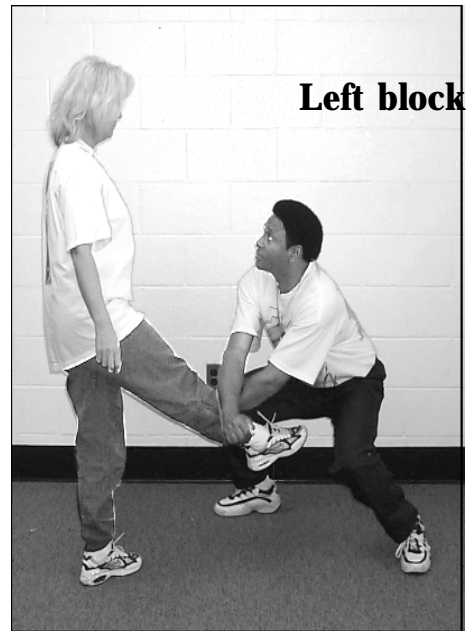
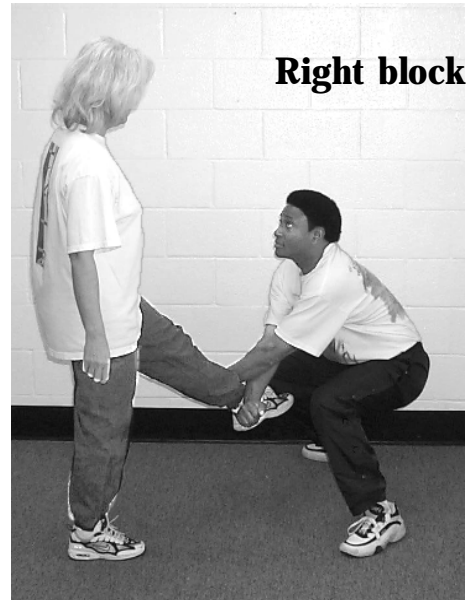
KICK BLOCK - METHOD A

The procedure...

- *1. Cross forearms in downward scissors with same arm on top.
- *2. Close hands making fists.
3. Have same foot forward maintaining balance.
- *4. Bend knees, keep back straight and head up.
- *5. Intercept kick on inside of scissors as close to the floor as possible.
- *6. In moving away, move to the outside of the kick.

Considerations

- *This technique should only be used in an emergency when it is not possible to avoid doing so.*
- *You should not grab the person's foot.*
- *Always keep your head up and eyes on the person who is kicking*





KICK BLOCK - METHOD B

The procedure...

*1. If forced up against a wall, step back with one foot/leg up in front.

*2. Turn the front of your body away from the person.

*3. To maintain balance, do not pick the front foot off the floor. Leave toe in contact with the floor.

*4. Do not lock knee. Keep knee bent.

*5. In the event the person kicks high, use hands to deflect the foot away.

*6. Do not grab the person's foot.

*7. Move away from the person as quickly as possible.



Considerations

- *Adjust the arms to the height of the kick.*
- *A kick should not be blocked unless there is no other choice.*
- *Using proper distance and stepping back may prevent injury to staff and the other person involved.*





Ask yourself

- *Is there imminent danger to the person or others that would call for this physical restraint?*
- *What do I know about this person when he/she becomes agitated, upset or frightened?*
- *Can I maintain safety without using physical restraint?*
- *Have I considered other less restrictive interventions? Have I been alert to this person's signs of increasing upset?*
- *Do I know what works to help this person calm down. If I don't, have I tried to get someone there who does? Have I tried to talk calmly with the person?*
- *Will it help to give the person some space or time?*
- *Can I safely restrain the person in a therapeutic hold by myself?*
- *Is help available if I need it?*
- *Are there other people in the immediate area who need to be cleared out of the way? Is there help to do this?*

Therapeutic Holds

Therapeutic holds are considered physical restraints and are closely monitored by your agency and the state. By law, physical restraint may only be used as a last resort and never as a means of intimidation or punishment. The therapeutic hold is a technique to physically restrain a person who may be out of control or assaultive (defined here as in imminent danger to self or others). The hold restricts the bodily movement of the person; therefore it must be used with caution. Your knowledge of the person and assessment of your abilities will determine your success in using this hold. Documentation and debriefing after this intervention are **REQUIRED**. Follow your agency's policies and procedure.

There are certain precautions to think about when using a therapeutic hold:

1. Although the amount of physical control needed depends on how severe the person's behavior is, your physical abilities and speed are also important considerations.
2. The hold should be adjusted so that you are only using as much strength as needed. This is called *controlling strength*. Use less strength as the person relaxes and calms down, or more strength if needed.
3. While the person is in the hold, a person trained in CPR needs to make frequent checks of his/her physical condition. Close observations of breathing and circulation to the hands and fingers are important.
4. Care should be taken to avoid injury from:
 - a. Head butts: lean back and step slightly to the side of the secured person.
 - b. Kicks: keep close and try to begin walking the person.
 - c. Scratches: keep person's hands tightly secured to their sides.

Placing a person in a therapeutic hold may provide all the control that is needed. Your first consideration must be to release and back off as soon as the person is calm or meets criteria for release. You and your co-workers may need to consider several options depending on the intensity of the situation.



THE NEVERS !

NEVER CROSS THE PERSON'S ARMS OVER HIS/HER CHEST, THIS CAN RESTRICT BREATHING, CRUSH THE CHEST, AND/OR CAUSE DEATH.

NEVER HYPER-EXTEND THE PERSON'S ARMS (PULLING THE ARMS OF THE PERSON, SO THAT HIS/HER ELBOWS CROSS OVER EACH OTHER), THIS CAN CAUSE INJURY TO THE PERSON'S SHOULDERS.

BOTH OF THESE ACTIONS ARE VERY UNSAFE!



Considerations

- Use only the amount of control necessary to provide safety for everyone.
- Respond clearly and immediately to any cues that the person is becoming less physically threatening. Do this by talking supportively to the person and relaxing your grip. Begin to plan your release.
- Hyper-extension of the person's arms in the therapeutic hold is **NOT ALLOWED**. It is not just a comfort issue, but a critical safety issue for the other person. During a struggle, locking your elbows to your sides can prevent hyper-extension. If you find you are holding the person's arms so that the person's elbows are crossed, stop immediately, and bring the arms down to the person's waist or release the hold entirely.
- If the person has a history of asthma, congestive heart failure, Down syndrome or any other breathing difficulties (cystic fibrosis), the therapeutic hold may be restricted or not allowed. Knowing the person's medical history is vitally important.

**THE OVERHEAD BLOCK TO THERAPEUTIC HOLD
METHOD A: ONE ARM BLOCK**

The procedure...

- * 1. Block the punch.
- * 2. Secure the wrist by placing the thumb under and closing the fingers over the back of the wrist. Caution: Do not twist arm or wrist.
- * 3. Adjust person's arm to their shoulder level.



- * 4. Step back with forward foot, pulling the person across the front of your body.





THE OVERHEAD - METHOD A, continued

- *5. Hold the person's arm fully extended and use your other arm to pin his free arm from the shoulder down to the front center of his body with an open hand.



- *6. Lower his extended arm over his pinned arm.



- *7. Transfer the wrist you are holding to your open hand.



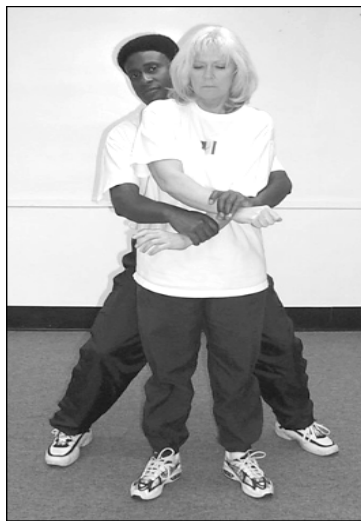


THE OVERHEAD - METHOD A, continued

- *8. With your now free hand, grasp the person's free wrist. Place your hands under the person's elbows. Secure the person's arms at his/her hip/waist level, below the base of the ribcage, keeping a firm grasp on wrists. Keep your elbows locked to the person's sides and maintain body contact.

Considerations

- *Make sure the arms are below the rib cage.*
- *Keep your head out of head butting range.*



- 9. While maintaining good body contact, shift your weight to one foot and place the other foot between the person's feet. Place the other foot directly behind causing the person to lean back slightly.





**THE OVERHEAD BLOCK TO THERAPEUTIC HOLD
METHOD B: TWO ARM BLOCK**

The procedure:

- *1. Block punch (see method B block for overhead punch).



Considerations

- *Two hands can also be used to secure wrist.*



- *2. Secure the wrist of the person (your right hand secures person's right wrist or left hand secures left wrist) by placing the thumb under the wrist and closing fingers over wrist.



- *3. Adjust person's arm to their shoulder level.



THE OVERHEAD - METHOD B, continued

- *4. Place the free arm in an L-shaped position on the back of the person's arm.



- *5. Slide other arm in L-shape position across shoulders as you step behind and beyond the person.



- *6. Pin the person's free arm.



- 7. Continue therapeutic hold as described in Method A, steps 6-9.

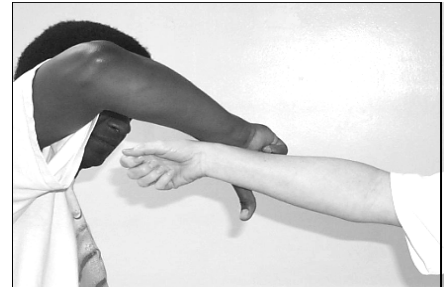


THE HOOK OR STRAIGHT PUNCH - METHOD A

*1. Block the punch.



*2. Secure the wrist by dropping the thumb down and raising the elbow at the same time. The thumb goes under the wrist, fingers go over the wrist.



3. Adjust person's arm to their shoulder level.



4. Continue with steps 4 - 9 as shown on the previous pages to carry out the therapeutic hold safely.



THE HOOK OR STRAIGHT PUNCH - METHOD B

*1. Block the punch.



*2. Secure the wrist by dropping the thumb down and raising the elbow at the same time. The thumb goes under the wrist, fingers go over the wrist.



3. Continue with steps 3 - 9 as shown on the previous pages to carry out the therapeutic hold safely.





THE UPPERCUT

The procedure.....

- * 1. Block the punch. (See the uppercut punch in Blocking Punches.)



Considerations

- *Keep your head out of head butting range.*

- * 2. Secure the wrist with the top hand by placing the thumb under and closing the fingers over the wrist, (keep bottom hand in place).



- * 3. Bring the person's arm to their shoulder level. Drop the block.



- 4. Continue with steps 4-9, Method A or B, as shown on the previous pages to safely carry out the therapeutic hold.

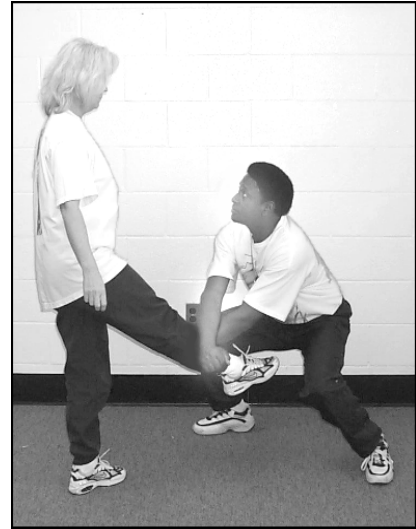


**THERAPEUTIC HOLD FROM KICK BLOCK
Method A (only)**

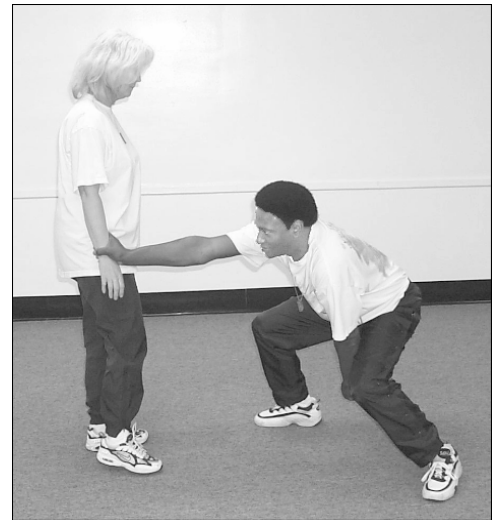
The procedure...

- *1. Block kick.

- 2. Move toward person's kicking leg.



- *3. Stay down as person's foot is moving back toward the floor. Reach in using top hand thumb down, and secure the wrist that is on the same side as the foot that is kicking.



- *4. Stand and bring person's arm up to shoulder level and proceed with therapeutic hold steps as previously shown.





THERAPEUTIC HOLD WRAP

The procedure:

- * 1. Approach the other person from behind and position your body close to the other person's body. Your feet should be on the outside of the other person's feet, with knees bent.



- * 2. Position arms in an upright L-shaped position, elbows pointed to the floor. Make contact using your forearm between attacker's shoulder and elbow.



- * 3. Move arms inward into a scissors position.



Considerations

- *At times it is easier and safer to move the person into a therapeutic hold from behind using "wrap method."*
- *If the person is physically unstable and pulling the person could cause him/her to fall.*
- *If the person is fighting with another person and you have to physically break up the fight.*
- *Keep your head out of head butting range.*



THERAPEUTIC HOLD WRAP, continued

Considerations

- *If the person has loose shoulders, be wary of hyperextending their arms.*
- *Never pin elbow over elbow.*
- *Keep your head out of head butting range.*

- *4. Continue to pin, slide hands downward and secure the other person just above the wrists.



5. While maintaining good body contact, shift your weight to one foot and place the other foot between the person's feet. Place the other foot directly behind causing the person to lean back slightly.





TWO HANDED HAIR PULL-FRONT

Prevention: Use a double L-shaped block to prevent the two handed front hair pull.

Considerations

- *Ask the person to let go of your hair. Be calm but firm. Do not let your voice add to an escalation of the situation. You may have to ask more than once. If you do not feel the person's fingers relaxing, then use release technique.*
- *Move away and consider ways to calm the person.*



The release...

- *1. Place hand over person's knuckles. (Stop the pull.)
- *2. Press down firmly with heel of hands until grip loosens.



- *3. Bend forward, drop one shoulder and move hands off head in the direction you are facing.



- *4. Step back.





TWO HANDED HAIR PULL-BACK

Considerations

- Ask the person to let go of your hair. Be calm, but firm. Do not let your voice add to an escalation of the situation. You may have to ask more than once. If you do not feel the person's fingers relaxing, then use the release technique.
- Performing this technique leaves you briefly vulnerable to a kick or being "kneed".
- Move away and consider ways to calm the person.

The release...

- *1. Press firmly on person's knuckles with flat hands, fingers open and straight. Apply pressure until grip loosens.



- *2. Maintaining pressure on knuckles, drop one shoulder. Turn under person's arms.



3. Release and move away.





ONE HANDED HAIRPULL-ASSIST

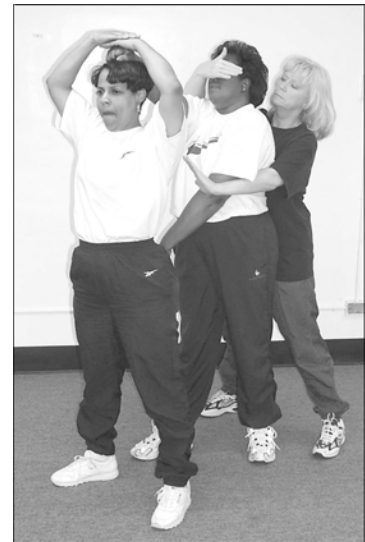
The release...

* 1. Press down firmly on person's knuckles with heels of your hands, hand over hand (preventing further pulling of hair).



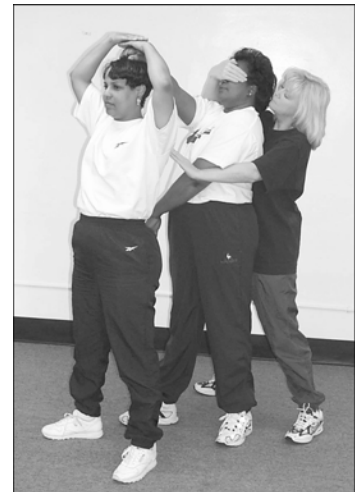
* 2. If you do not feel a release of the knuckles, indicate need for help.

* 3. Helper approaches from the rear and assumes the therapeutic hold wrap position, covers the person's eyes with hand on same side as person is pulling hair, then pins the person's free arm. Option: once free arm is pinned, you may secure the wrist of pinned arm and cover eyes with free hand.



4. Helper leans person backward, resting the person against helper's body.

5. If the person releases, you can either release the hold or place them in a therapeutic hold wrap.



Considerations

■ **Do not tilt the head back.**

■ *The person whose hair is being pulled should lean back while the helper is tilting the person back.*



ONE HANDED HAIRPULL-ASSIST, continued

Considerations

■ **Judgment call:**
If only one helper is available, the helper may have to decide between stabilizing the person or releasing the person's fingers. If the person is pulling staff off balance or is attempting to kick or "knee" the staff, the helper should use the description in number 3 above. However, sometimes the person's fingers are simply tangled in your hair without intent to harm or escalate the situation. You may need help to release the person's fingers from your hair.

6. If there is a second person, they can:

- * a) Enter to the other person's pinky side.
- * b) Second helper frees the person's hand from hair by using both thumbs.



c) One thumb pries each finger out of the the hair being pulled.



d) The other thumb slides under each released finger to prevent regrabbing.





ONE HANDED HAIRPULL-ASSIST, continued

Considerations

The first helper may:

- *Position his/her body directly behind the person (squared up behind the person, with feet spread as wide as shoulders) before tilting the person slightly back.*

OR

- *Position his/her body directly behind the person, but helper is turned to the side, before tilting the person slightly back.*
- *Release the person, step away and consider ways to calm the situation.*

- e) Once all fingers are released, the hold is maintained on the hair puller's hand and placed in the first helper's open hand. The first helper proceeds to a therapeutic hold.





Considerations

- *Move away and consider ways to calm the person.*

TWO HANDED HAIRPULL-ASSIST

The release...

The staff presses down firmly on the person's knuckles with heels of hands (preventing further hair pulling).

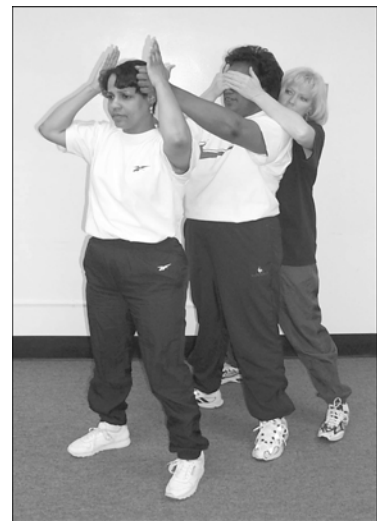
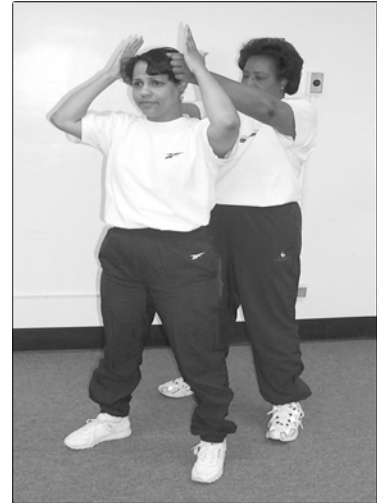
Staff indicates need for help.

*1. Helper approaches from rear and covers person's eyes with both hands.

2. Lean the person backward supporting person's neck and head against body.

3. If person does not release the hold, staff assesses the situation and indicates need for more help.

Note: If a second helper is not available, the first helper may decide to attempt release of hands as described in 1 hand hair pull assist.





TWO HANDED HAIRPULL-ASSIST, continued

4. Second helper moves to one side of the person and releases fingers as previously described.



*5. When all fingers are secured, first helper pins arm as staff and second helper release his/her hold.

Considerations

- *When the hold is released you can move away or place the person in a therapeutic wrap.*

*6. Second helper moves to the other side and follows the same procedure for release.





CAUTION:
NEVER PULL OR
JERK AWAY
FROM A BITE.

Considerations

- *As an added distraction, staff can cover the person's eyes with the hand that is holding the person's nostrils.*
- *Upon release, move away from the person and consider ways to calm the situation.*
- *Practice universal precautions immediately.*

OPTIONAL BITE RELEASE

Use if Core Bite Release method is not successful.

When someone bites you, your natural tendency is to pull away. This may actually increase the intensity of the bite. Do not over react.

The release...

ASSESS PERSON'S CONDITION.

*1. The staff may press the person's head into bite by placing one hand at the back of the person's head, near the crown. Keep hand in place while carefully walking the person backwards to the nearest wall.

*2. When the person is braced against the wall, turn sideways and bend your closest leg at the knee and cover the person's knees to prevent a kick.

*3. Remove hand from crown of the person's head.

*4. Hold the person's nose as you roll your arm into the person's mouth to complete a seal. Continue to roll arm in and down to gain release.





BITE RELEASE ASSIST

The release...

- *1. Push body part being bitten into person's mouth, if possible. If release is not gained, call for help.



Considerations

- Upon release, move away from the person and consider ways to calm the situation.
- Practice universal precautions immediately.
- Check the person for possible mouth injury if index fingers were used on person's jaw.

- *2. Assistant covers person's eyes.



- *3. If release is not gained, the assistant gradually applies rubbing pressure with the middle joint of their index finger to upper part of person's jaws, moving downward to open person's mouth.





BACK CHOKE BEND

Quick, immediate action is essential. When being choked you must protect your windpipe by quickly tucking your chin. This tucking not only decreases the available space for the person to choke, it also contracts the muscles around your windpipe.

The release...

*1. Tuck chin.



*2. Secure person's wrists with hands.



*3. Bend at the waist slightly.



Considerations

- *Balance is important to perform this technique. Do not cross your feet as you make the turn.*
- *Step back and consider ways to calm the person.*
- *This move may make the person lose his balance, falling on staff.*
- *Do not bend forward too far. It puts stress on the person's shoulders and decreases your space to move upward.*



BACK CHOKE BEND, continued

- *4. Turn to either side, maintaining bent position until directly in front of person.
Note: person's arms will be crossed.



- 5. Move head up against person's crossed arms.





BEAR HUG-BICEP RELEASE

This release method should only be used when the other bear hug release does not work and you feel you are in grave danger. If your arms are caught in front, as a last resort use this technique. The release must be done quickly and with enough power to release the hold. It may possibly bruise the person's arm.

Considerations

- You may need to use either elbow or both elbows at the same time on the person's biceps.
- Can be used if someone is lifted off the floor.
- Can be used if hands are trapped in front.
- Don't forget to be calling for help as you are working towards release.
- After the incident has calmed, check the person for bruising. Fill out appropriate injury reports if applicable.

The release...

*1. Bend forward.



*2. Pull elbow up slightly positioning it on the person's bicep muscle.

3. You can grab your own hand to help with leverage on this release.





BEAR HUG-BICEP RELEASE, continued

*4. Lean positioned elbow into bicep muscle until person releases.



5. Turn, face the person.

*6. Back away quickly.





MODIFIED LIMITED CONTROL WALK FROM STANDING POSITION

Procedure may be used when the person resists walking and staff is unable to manage the person alone.

Caution!

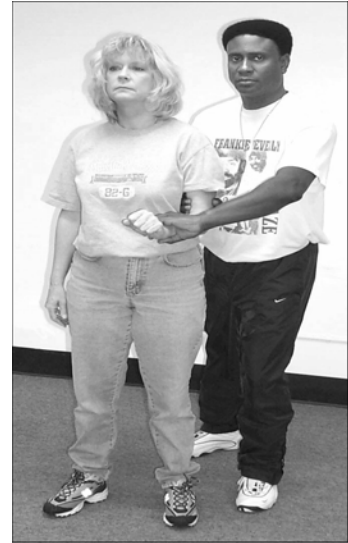
If at any time the person becomes resistive, immediately and safely release the hold.

The procedure:

- *1. Staff will follow the procedure to place person in the Limited Control Walk. If unable to move the person, call for help.

- *2. Helper approaches from the rear to the person's free side and assumes the same position as the staff.

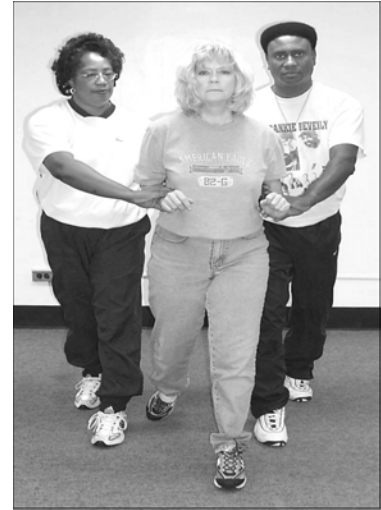
- *3. Staff assumes command and says, "READY" and helper indicates by nodding. Staff gives command "WALK".





**MODIFIED LIMITED CONTROL
WALK FROM STANDING POSI-
TION, continued**

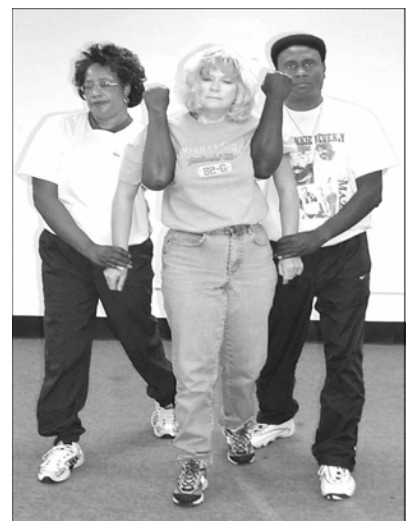
*4. Walk the person to designated area.



*5. If the person attempts to drop while being walked, both staff and helper will immediately slide the arm that is securing the person just above his/her elbows under the person's arms until staff and helper's elbows are under the person's armpits and locked in an L-shaped position.



*6. At the same time they move the person's arms into a downward position, close to the person's body. Con-





tinue to walk the person to the designated area.

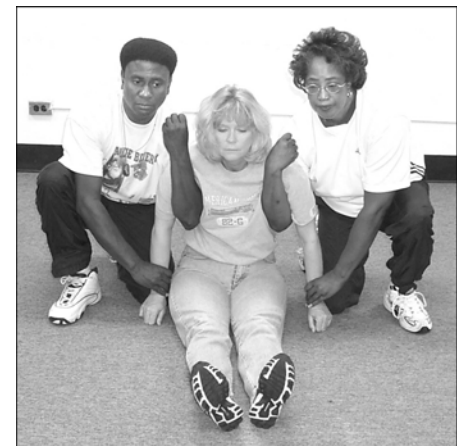
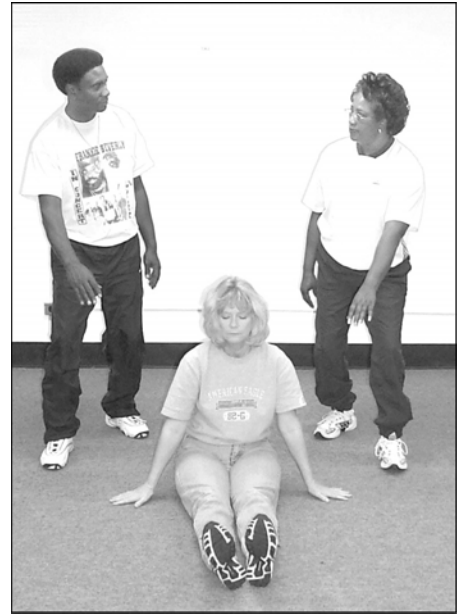
MODIFIED LIMITED CONTROL WALK FROM THE FLOOR

Considerations

This technique is to be used only if the person sits down on the floor/ground and is resisting getting up and walking with staff. Once the technique has begun, if the person becomes aggressive or resistive to the point of needing to apply pressure, immediately and safely release hold.

The procedure:

- *1. Two staff on the shoulders make eye contact and maintain that eye contact until the wrists of the individual are secure.
- *2. The two staff approach person from behind, moving to each side, kneeling on one knee. At the same time using arm farthest away from the person, both staff secure person's arm near the wrist by placing palm of hand on top of person's wrist while wrapping fingers and thumb to underside of wrist.
- *3. Using arm closest to person, staff place their forearms under person's arms until staff's elbows are under person's armpits. Staff's arms





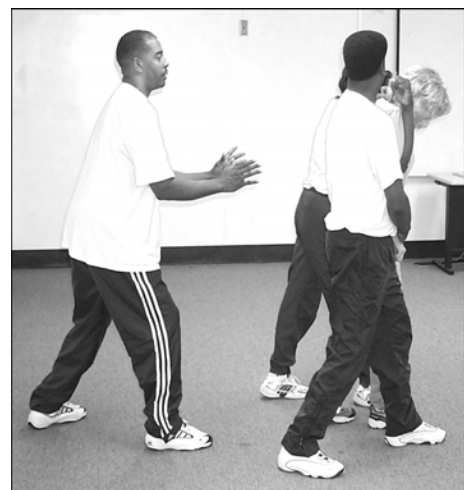
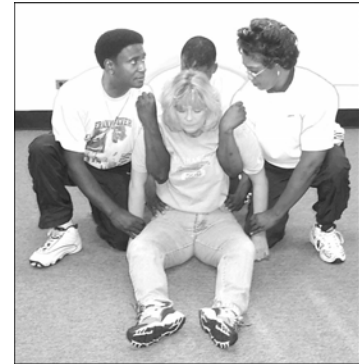
should be locked at the elbow into an “L” shaped position. Person’s arms should be held downward and close to his/her body.

Considerations

- *Either knee will work.*



- *4. Third staff approaches from the rear, positions self onto one knee and secures the person by placing both hands on the person’s hip.
- *5. This is the only technique that two staff enter at exactly the same time. The staff on the person’s right side assumes command and says “READY”. Helpers indicate ready by nodding.





Ask yourself

- *Must the person walk at this moment in time?*
- *Could talking softly with the person or waiting a moment or two lead to the person cooperating with you?*
- *Could the use of this technique lead to further escalation?*
- *Could you back down? Could releasing the therapeutic hold or moving to the limited control walk de-escalate the situation?*
- *Can you safely handle this situation alone? Is help readily available if you need it?*
- *Is there anything in the immediate environment which would get in the way of your moving forward with the person? (furniture, other people, space)*

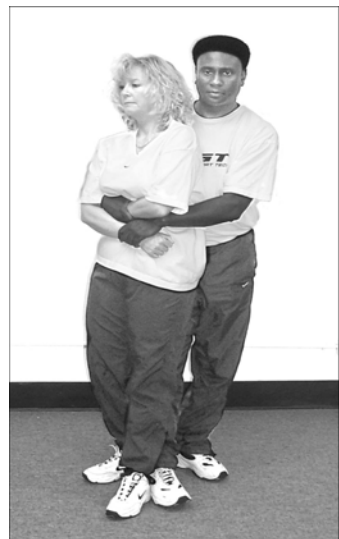
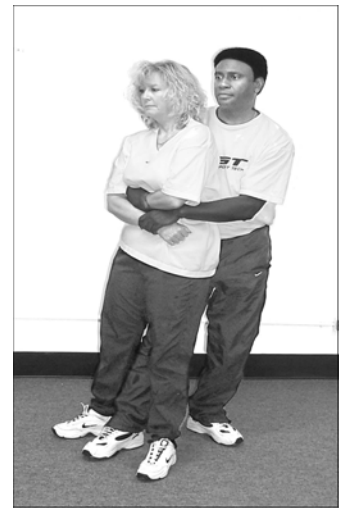
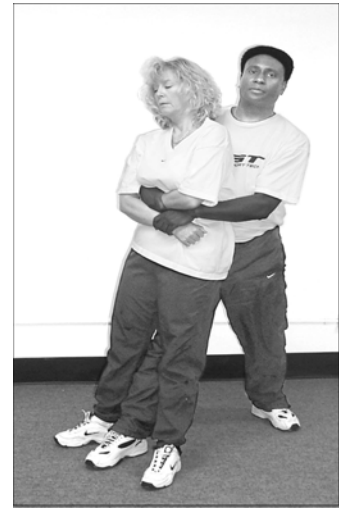
If you are unsure of the answers to these questions, waiting can buy you and the person time to figure out the best solution for everyone involved.

- *6. Staff in command says, “LIFT”. (CAUTION: Use good body mechanics and be aware of the possibility of head butting.) Staff lift person and walk forward to designated area. Helper on hip assists with the lift then releases.

ONE PERSON THERAPEUTIC WALK

The procedure...

- *1. Staff places person in a therapeutic hold.
- *2. While maintaining close body contact (upper body should not move), adjust the back foot up for balance.





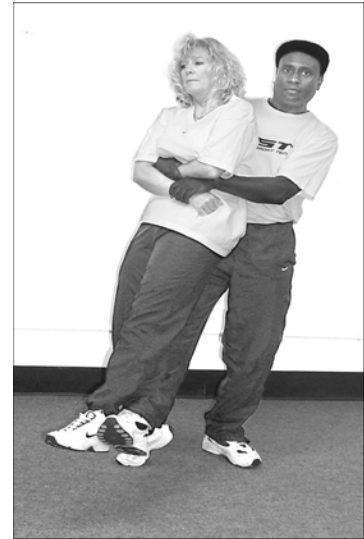
Considerations

- *Most of the time the person will begin to walk with you. Forced walking is very rare. Sometimes it will take a few minutes to encourage the person to begin the walk. Seldom is there a need to rush. You already have the person stabilized in the therapeutic hold.*
- *Safety for the person is your most important responsibility.*
- *Forced walking can lead to escalation of the situation.*
- *This technique can be difficult to do if you have to go long distances.*
- *Should rarely occur when help is reasonably available.*

- *3. Staff moves foot that has been placed between person's feet to outside rear of person's foot, at the heel.

ONE PERSON THERAPEUTIC WALK, continued

- *4. Staff, keeping leg straight as though in a cast, (to prevent kneeling the person), leans the person back slightly, while lifting the person's foot at the heel causing the person to step forward. (Walking the person backward may be required to go through doorways or to position the person in a chair.)
- *5. Staff maintains close body contact from shoulder to hip to designated area.



CAUTION: STAFF MUST NOT USE KNEE TO FORCE PERSON TO WALK OR TO LIFT PERSON OFF THE FLOOR.





Considerations

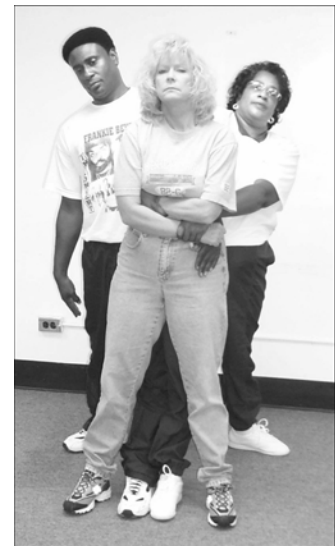
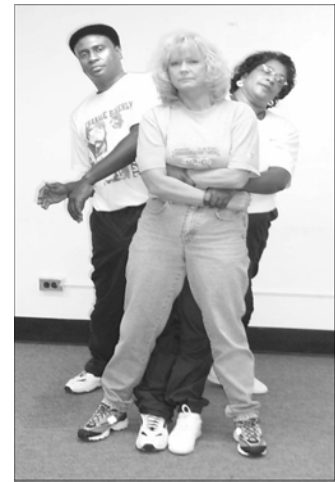
- *Most of the time the person will begin to walk with you. Forced walking is very rare. Sometimes it will take a few minutes to encourage the person to begin the walk. Seldom is there a need to rush. You already have the person stabilized in the therapeutic hold.*
- *Talk softly and calmly with the person to avoid escalation.*
- *When releasing the person, release in a slow reassuring manner.*
- *Move away and consider ways to calm the person.*

On occasion, the person may try to sit down or pick his/her feet off the floor. If this should happen, turn to the side and kneel down with the person, making sure that the knee closest to the person lands before the person's rear end.

TWO PERSON THERAPEUTIC WALK

The procedure...

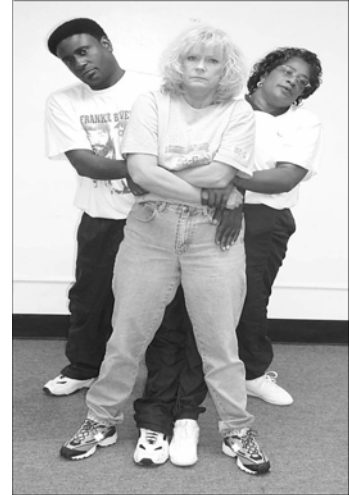
- *1. Staff places person in therapeutic hold, and indicates the need for help.
- *2. Helper approaches from rear to person's open side and places foot that is closest to person beside staff's foot (which is between the person's feet) and hip against staff's hip creating a seal.





TWO PERSON THERAPEUTIC WALK, continued

- *3. Helper then places inside arm around the person and places open hand on person's hipbone. Hand is placed flat on person's hipbone, with fingers pointed to floor, covering the person's fingers to keep them from scratching, and pulls back slightly.



- *4. Helper secures person's wrist nearest him with free hand by placing his hand at a point above staff's hand and sliding downward to secure wrist.



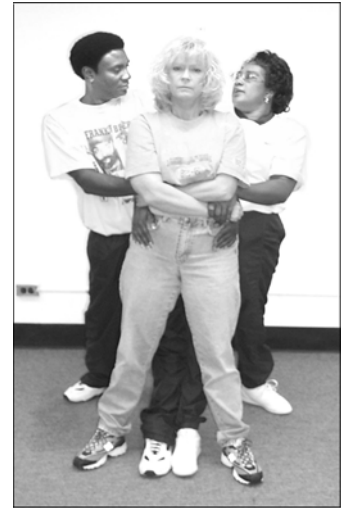
- *5. Once staff feels the "bump" indicating that the helper has secured the person's wrist, the staff releases grasp on that wrist, and proceeds to secure hold by placing opened hand on person's hipbone, fingers pointed to the floor covering person's fingers to keep them from scratching, and pulling back slightly.



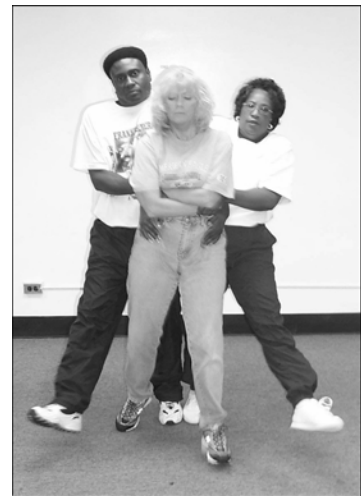


TWO PERSON THERAPEUTIC WALK, continued

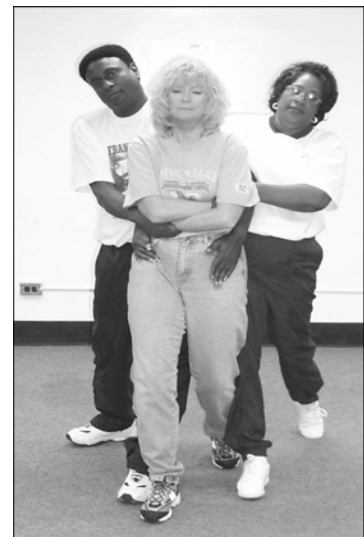
- *6. Staff in charge looks at partner and says "Ready." Helper indicates ready by nodding.



- *7. Staff says, "Walk." Staff and helper take the first step with their outside feet.



- *8. Inside foot comes out as walk begins. While maintaining good body contact, person is walked to designated area.





ESCAPE ATTEMPT

Considerations

- *Be alert to the person attempting to sit down . If he/she should start to drop out of the hold and land without your support, there could be injury to either or both of you.*
- *You must support the person's descent to the floor with your body. As you are sitting down, make sure that your knee closest to the person bends away from the person's back. Your knee should touch down before the person's rear end.*

The procedure:

- *1. The staff secures person in therapeutic hold, and the person starts to drop to floor and the staff provides a safe supported descent to the floor. **This is not a “take down” technique!**
- *2. The staff maintains close body contact (hip to shoulder contact) and supports the person as he is lowered to the floor, buttocks first.





THERAPEUTIC WALK TO CHAIR

The procedure...

Considerations

- *Make sure the chair being used is sturdy.*
- *If the person is extremely resistive, other techniques are better choices and may be safer.*
- *Size, strength, and relative level of resistance of the person is an important consideration. Do not put a person who weighs over 100 pounds in a chair. A large adult can break the back of the chair, and cause additional danger to both parties.*
- *Make sure knee is to the chair not the person.*
- *Release the person slowly, move away, and consider ways to calm him/her.*

- *1. The staff places the person in a therapeutic hold and moves the person toward the chair using one of the previously learned walk procedures, or have helper bring chair in from the rear..



2. The person is walked around the chair until his back is toward the chair.



- *3. Person is placed in the chair while the staff maintains the therapeutic hold.
- *4. The staff places one knee on floor pressing shoulder in back of chair for support.
- *5. The staff moves his head to one side to avoid head butts by the person.

ADDITIONAL INFORMATION: Staff may provide additional support for the chair by pressing one knee into the back of the chair while balancing his weight on the other knee.



THERAPEUTIC HOLD IN CHAIR WITH ASSISTANCE

The procedure...

- *1. Staff completes “therapeutic walk to chair” and indicates need for help. Helper can bring chair to staff and place behind staff, holding chair for support while staff sits person in chair.

Considerations:

- *Make sure the chair being used is sturdy.*
- *If the person is extremely resistive, other techniques are better choices.*
- *Make sure the person is not actively struggling.*
- *Size of the person is an important consideration. Do not put a person who weighs over 100 pounds in a chair.*
- *Release the person slowly, move away, and consider ways to calm him/her.*



- *2. Helper approaches from rear, positioning self beside the person.



- *3. Helper kneels with closest leg maintained in upright position beside person's leg and helper's other knee is positioned on floor to maintain balance.

- *4. Helper places hand/arm closest to person across person's legs above the knees and other hand/arm below the knees for control.





Considerations

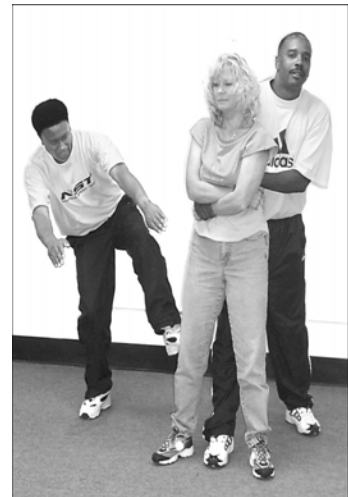
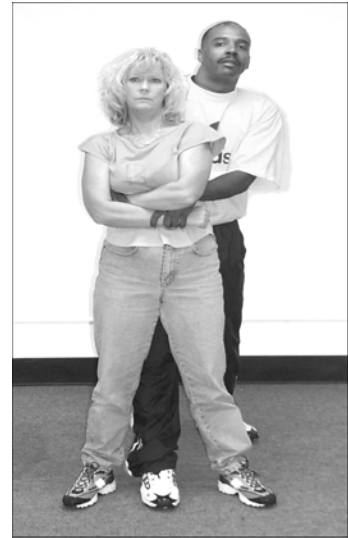
- Remember that this technique can be embarrassing and frightening to the person. **THIS IS TRUE FOR ALL OF THESE INTERVENTIONS**
- Do not pin face down on the floor a person who has Down's Syndrome, asthma, congestive heart failure, or any history of breathing problems or any medical condition that may contraindicate the procedure. Staff and helper's elbows and knees should never be used to hold the person down.
- Constantly check the person for circulation or breathing difficulties; if any difficulties are found, the person must be released immediately.
- Do not push off the person as you get up to leave the area.
- Do not push off on person's back.
- Be aware of the surface the person is lying on and make accommodations accordingly.

Review Health Status Check in the Core Interventions workbook on page 7.

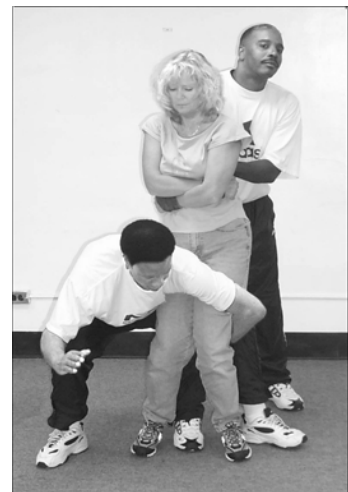
TWO PERSON THERAPEUTIC CARRY

The procedure...

- *1. The staff secures person in a therapeutic hold and leans person slightly backward, indicating need for help.
- *2. Approaching from the rear, the helper slides the foot closest to the person between the person and staff, at the bend of the knee.



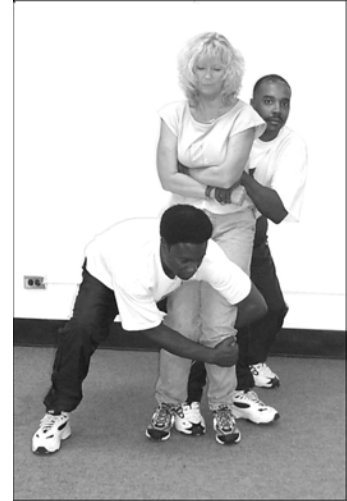
- *3. Helper positions arm closest to person over legs slightly above knees and positions arm furthest from the person over legs slightly below knees.





TWO PERSON THERAPEUTIC CARRY, continued

*4. Helper secures legs tightly (helper may move arm below knees into position behind person's legs, wrapping tightly on "lift" command).

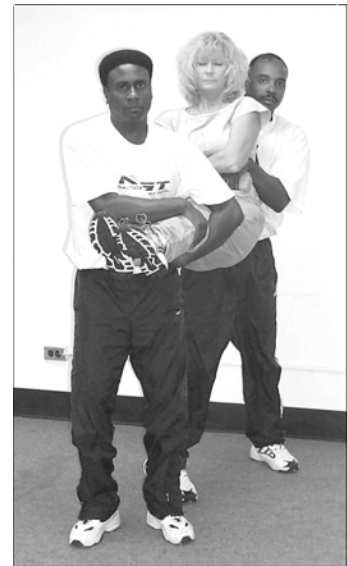


*5. Helper indicates readiness.

*6. Staff readjusts hold by sliding his body down so person is positioned on his hip.

*7. The command "lift" is indicated by the staff.

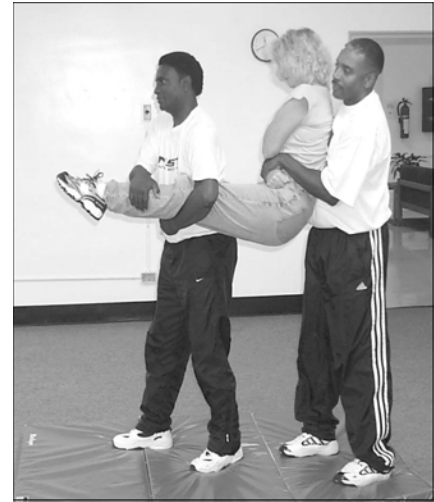
*8. The helper lifts the legs and leads toward designated area.





TWO PERSON THERAPEUTIC CARRY, continued

*9. The staff indicates to lower the person.



*10. The staff and helper kneel as the person is lowered to the floor, buttocks first.



*11. After lowering the person to the floor, staff should adjust for balance before rolling the person face down.



TWO PERSON THERAPEUTIC CARRY, continued

The person is rolled away from the exit, so staffs' backs are toward the exit.

12. To avoid a body slam, staff on the shoulders should make sure his/her elbow touches the floor before the person's shoulder touches down.



- *13. The staff maintains hold on closest wrist and applies pressure to the opposite shoulder, keeping knees in contact with person's arm.



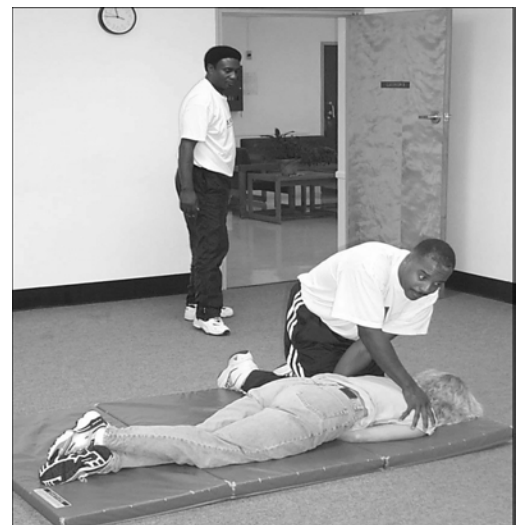


TWO PERSON THERAPEUTIC CARRY, continued

*14. The helper crosses the person's legs (farthest leg crossed towards helper) and applies downward pressure (with elbows locked), maintaining knees in contact with the person's legs.



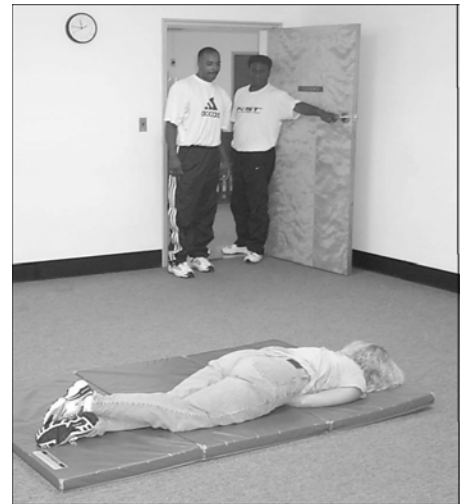
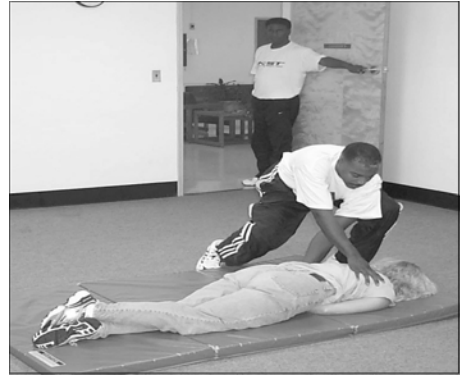
*15. The command to leave is given by the staff on the shoulder. The helper leaves by coming up on one knee, shifting his/her body weight off the person and exits.





TWO PERSON THERAPEUTIC CARRY, continued

*17. Staff exits, monitoring the person.





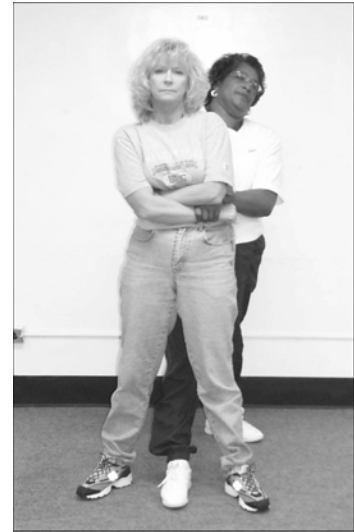
THREE PERSON THERAPEUTIC CARRY

Considerations:

- *Do not pin face down on the floor a person who has Down's Syndrome, asthma, congestive heart failure, or any history of breathing problems.*
- *Staff and helper's elbows and knees should never be used to hold the person down.*
- *Constantly check the person for circulation or breathing difficulties; if any difficulties are found, the person must be released immediately.*
- *Helper in the middle may pin the person down by placing hands on each side of hip girdle with his/her fingers facing outward. Elbows must be locked.*
- *Once the person is on the ground, the staff at the head is the lead.*
- *Do not push off the person as you get up to leave the area.*
- *Be aware of the surface the person is laying on and make accommodations accordingly.*

The procedure...

- *1. The staff secures the person in a therapeutic hold and leans the person slightly backwards, indicating need for help. (Indicate kind of help, e.g. "help to walk" or "help, shoulder position").



- *2. First helper assumes "two person therapeutic walk" position approaching from the rear.





THREE PERSON THERAPEUTIC CARRY, continued

- *3. The second helper assumes “two person therapeutic carry” leg position and indicates ready.



- *4. Staff and first helper readjust hold by sliding their bodies down so person is positioned on their hips. Additional helpers can be added, for safe transport if necessary, at the person’s thighs and/or at the person’s buttocks.





THREE PERSON THERAPEUTIC CARRY, continued

*5. Staff indicates lift.

*6. Second helper lifts the legs and leads toward the designated area.



*7. Staff indicates to lower the person.



*8. The staff and helpers kneel as the person is lowered to the floor buttocks first. Staff and helpers knees must land before the person's buttocks.



Release From a Seated Position

1. Staff secures the person in a therapeutic hold. While holding or walking the person, if the person begins to struggle and drops to the floor the staff must provide a safe, supported descent to the floor.



2. As the person starts to sit down, the staff steps back with their leg that is behind the person or forward with their leg that is outside the person. While maintaining close body contact staff lowers the person to the floor, buttocks first, in a seated position.
3. As the person is seated, staff maintains hold of the person's wrists, slides their shoulder down the person's back to avoid head butting, and positions themselves on both knees, with their knees spread wider than the person's hips.



4. If the person is calm, staff should release them from this position, move away and consider ways to further calm the person.

Participant Workbook

5. If the person is not calm, staff should hold them until calm or until time limits have been reached. If additional staff helpers are needed to safely secure the person, the following procedure should be followed:

A. If the person is kicking, staff helper is called to secure the legs. Staff side step in with back to the person's feet (being very observant for biting, kicking, head butting and spitting). Staff kneels at person's knees. Staff may apply downward pressure on legs above the knees (careful not to apply excessive pressure) or wrap legs up with both arms, lift legs slightly, sliding staff knee and thigh under legs for support, staff then lean back slightly.

B. If a second helper is needed to further ensure safety, they enter from the back beside the first staff. Assume the same position as first staff, place hand on opposite hip then secure wrist that is on their side. When first staff feels wrist is secured, they release wrist that has been secured and place their hand on hip below that wrist.

C. When all is calm the first staff instructs "legs leave" legs helper gets up, moves away but remains available to the situation. First staff then instructs "shoulders leave", both staff kneeling behind the person, release the person, get up, without pushing on the person and move away considering ways to further calm the person.

Teaching Points

- If possible the person should be secured, walked and released from a standing position.
- If the person is to be released from a seated position staff helpers should be called only if the safety of the person, staff or others in the area is in question.
- This is a restrictive procedure and must be monitored for safety by a staff that is not involved directly in the technique. Additionally, debriefing must be completed as soon as possible after the procedure is complete and should involve the person, if at all possible.
- When supporting the person to the floor, staff's knee must touch the floor before the person's buttocks.
- When in any of the three positions, staff must be aware of head butting, kicking and/or biting.
- This procedure is never to be used as a means to take a person down to the floor.

Two Person Standing Carry

The procedure...

1. The staff secures person in a therapeutic hold and leans person slightly backward, indicating need for help.



2. Approaching from the rear, the helper slides the foot closest to the person between the person and staff, at the bend of the knee.
3. Helper positions arm closest to person over legs slightly above knees and positions arm furthest from the person over legs slightly below knees.



4. Helper secures legs tightly (helper may move arm below knees into position behind person's legs, wrapping tightly on "lift" command).

Participant Workbook

5. Helper indicates readiness.
6. Staff readjusts hold by sliding his body down so person is position on his hip.
7. The staff verbally indicates the command “lift”.



8. The helper lifts legs and leads toward designated area.
9. The staff indicates to lower the person.
10. The staff and helper kneel as the person is lowered to the floor, buttocks first.
11. Lower the person to the floor.



12. Release the person when calm, lead staff indicates legs released first.

Three Person Standing Carry

The procedure...

1. The staff secures the person in a therapeutic hold and leans the person slightly backwards, indicating need for help. (Indicate kind of help, e.g. “help to walk” or “help, shoulder position”).



2. First helper assumes “two person therapeutic walk” position approaching from the rear.



3. The second helper assumes “two person therapeutic carry” leg position and indicates ready.

Participant Workbook



4. Staff and first helper readjust hold by sliding their bodies down so person is positioned on their hips. Additional helpers can be added, for safe transport if necessary, at the person's thighs and/or at the person's buttocks.
5. Staff indicates lift.



6. Second helper lifts the legs and leads toward the designated area.
7. Staff indicates to lower the person.
8. The staff and helpers kneel as the person is lowered to the floor buttocks first. Staff and helpers knees must land before the person's buttocks.

Participant Workbook



9. Release the person when calm, lead staff indicates legs released first, then shoulders released, staff steps away.



Considerations

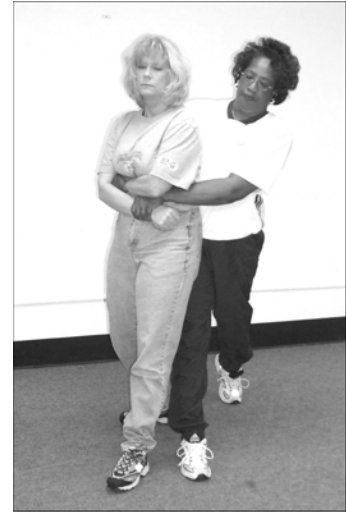
- *Being in charge has to do with who initiates the restraint or the position staff find themselves in upon release. This is not a supervisory issue but one of proximity.*
- **Before you roll the person face down, ask yourself:**
 - *Is the person telling you “no” by sitting down?*
 - *Can sitting down with the person and waiting a few minutes, lead to him/her becoming calmer?*
 - *Can the person be maintained safely while seated upright?*
 - *Do not pin face down on the floor a person who has Down’s Syndrome, asthma, congestive heart failure, or any history of breathing problems or other medical conditions that would contraindicate the procedure.*

THREE PERSON CARRY FROM FLOOR

This technique should **only be used when for safety reasons**, the person is on the floor and must be transported to a safer area.

The procedure...

*1. Staff secures person in therapeutic hold and attempts one person walk.



*2. When person initiates drop to the floor, staff supports the person with his/her body.



*3. Once the person’s buttocks have touched the floor, staff carefully rolls him/her over, face down.





THREE PERSON CARRY FROM FLOOR, continued

**Considerations,
continued**

■ *If the person must be moved due to health or safety reasons, the staff uncrosses the arms to allow one staff to enter on either side to assume the Modified Limited Control Walk from the floor position. Once the arms are uncrossed, the staff will secure the wrists immediately. All three staff should move at the same time. The staff that started the escape attempt will assume the 3rd person position behind the person. Continue with the Modified Limited Control Walk from the floor.*

- *4. Maintain hold on closest wrist and apply pressure to the opposite shoulder, while keeping knees in contact between the shoulder and elbow. Staff indicates a need for help, being specific where you want helper(s) to help.



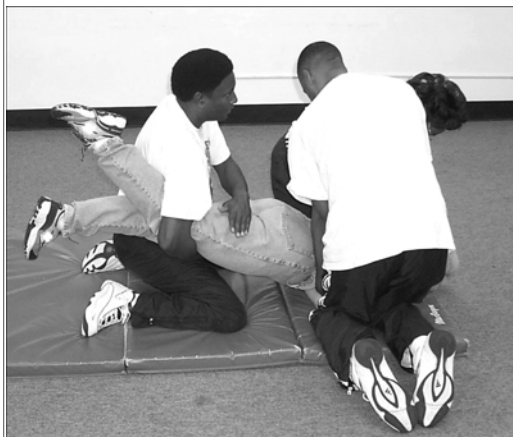
- *5. First helper approaches from the person's head area opposite the staff, securing the free wrist with hand closest to person's feet and applying downward pressure to the opposite shoulder, keeping knees in contact with the person's arm.





THREE PERSON CARRY FROM FLOOR, continued

- *6. Second helper approaches at the waist, kneeling and wrapping the person's thighs with both arms, then lifting and sliding downward to tightly secure the person's knees while leaning back.





THREE PERSON CARRY FROM FLOOR, continued

*7. The staff and first helper maintain hold on person's wrist, while locating and securing the person's same (right wrist, right elbow) elbow with the other hand.



8. The staff indicates ready and observes until everyone is positioned on one knee.





THREE PERSON CARRY FROM FLOOR, continued

*9. The staff indicates “lift to knee level.”

*10. Person is lifted onto team’s knee and supported while holds are secured.



*11. The staff indicates “lift” and person is lifted to hip/waist level.

*12. Shoulder positions lead the way to designated area.



*13. Staff indicates to “lower to knee,” person is lowered to team’s knees.





THREE PERSON CARRY FROM FLOOR, continued

*14. Staff indicates to “lower to floor” and person is lowered to floor, upper parts (shoulders) of the person’s body touching first.



*15. Staff and helper on the shoulders maintain hold on the closest wrist and apply downward pressure to the opposite shoulder, keeping knees in contact with person’s arm.



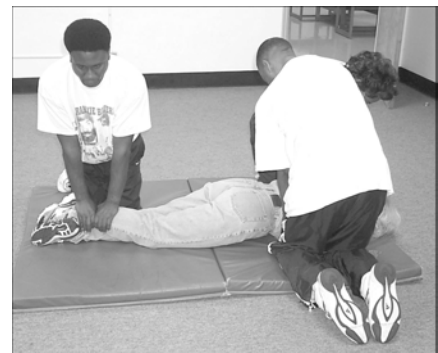


THREE PERSON CARRY FROM FLOOR, continued

*16. Helper on the legs makes a slight motion forward to roll elbows flat and lowers legs to floor.



*17. Helper crosses person's legs, applying downward pressure at ankle, keeping knees in contact with person's leg. The shoulder staff (or helper) whose back is to the door assumes charge (or command).

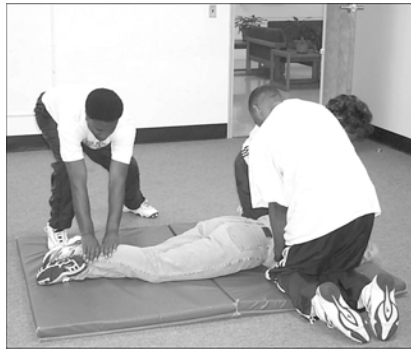




The staff in charge decides what order the helpers safely exit the room.

THREE PERSON CARRY FROM FLOOR, continued

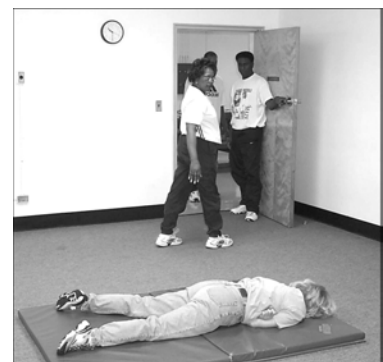
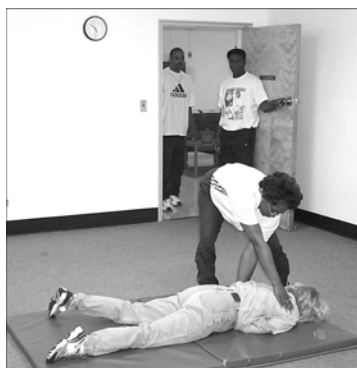
*18. The helper on the legs leaves, as indicated by the staff in charge, observing until the others make a safe exit (this helper indicates “exit is clear”).



*19. Helper on shoulder (facing the door) leaves next (around the person's head) as indicated by staff in charge, observing until the staff in charge can make a safe exit.



*20. Staff in charge, rocks weight back on his/her knees, releases and moves back away, releases hold, and clears area.





THREE PERSON CARRY FROM FLOOR, continued

Note: If additional help is needed:

- **Fourth person:** A fourth person may be used to assist in the three person carry from the floor by entering after the other three staff have secured their initial positions. This helper is directed by the staff in charge to either (1) approach at the person's waist area and apply downward pressure to the hip girdle (this is to control bucking and/or excessive body movements and to assist in safely lifting and carrying the person) or (2) enter at the person's shoulders to assist with the lift or to cover the eyes (commands for assigned position is given by the staff in charge).
- **Fifth person** can assist in a three person carry from the floor by entering after the other four people have secured their positions. This helper is directed by the staff in charge to (1) assist with lifting the person at the waist or shoulders, or (2) cover the person's eyes with his hands and should aid in the transport.



PREPARING FOR CLOSURE

OBJECTIVES: To help the person remain safe without the need for external controls and to seek to calm the person when ending the restrictive intervention.

It is important to remember that the immediate goal of the restrictive intervention is to insure the safety of the person and those in the surrounding area.

- Once the person is restrained, staff involved should insure that the person is safe within the intervention. They are breathing freely, no apparent circulation problems and not subject to injury from things like ground surfaces.
- With people who are consistently acting in unsafe, aggressive and threatening ways, it is best not to talk much during the physical intervention other than to insure that the person is not having physical distress.
- Staff should be alert to signs that the person is beginning to calm and resistance is slowing down.
- Release of physical control should be done gradually. Do not release as soon as the struggling stops. Release one part of the body at a time or allow one staff member to exit at a time.
- Though the person was “safe” physically during the correct performance of the restrictive intervention, the procedure is oftentimes a frightening and humiliating experience.
- Staff should consider ways to begin rebuilding the relationship with the person. As soon as possible look for an opportunity to talk quietly with the person to begin this rebuilding process.
- Make sure you check with the person about any skin burns, bruises or other soreness as soon as possible. Then check with any of your co-workers involved in the restrictive intervention.



ROUTINE COMMUNICATION/FOLLOW-UP

OBJECTIVES: To communicate appropriately details of an aggressive or violent episode and report the use of restrictive interventions to proper channels.

After a crisis situation, you will need to notify people and document what happened according to your agency's policies. Your documentation should describe what happened before, during and after the event. Include a description of the person's behavior leading up to the event, efforts on the part of staff to use positive ways to avoid the escalation, a description of the intervention itself, when and how the event ended, and how staff assisted the person in "debriefing" or gaining closure over the event.

PREVENTING FURTHER EPISODES

When the crisis is over and the intervention concludes, a designated staff person should attempt to re-establish the therapeutic relationship. If appropriate, this may include a neutral and non-threatening interaction. It may be therapeutic for some individuals to resume the scheduled activities with interaction occurring during or after the activity. Staff may employ a variety of approaches to help the person feel secure and non-threatened. This could include providing a drink, scheduling the interaction in a pleasant environment, or similar arrangements. During debriefing, staff should use a calm tone of voice, be non-judgmental, and focus on helping the person develop skills and strategies to minimize future crisis episodes.

The person may have difficulty putting into words what happened from his/her point of view. If the person is reluctant, it may help for you to describe what you saw, heard and thought. Your goal here is to find out what and why the incident happened from the person's point of view and begin to rebuild your relationship. At a later time you can help the person deal with the consequences of his/her actions. You may have to come back to the person several times to get the whole picture. If the person does not have the skills to tell you what happened, you might try gestures, role playing, or other ways to communicate without words to see if that will help you get the information.



The person may never be able to tell you what he/she thought happened. You will then have to rely on your co-worker's observations and your personal understanding of what has happened.

It is important that you debrief with your co-workers. This debriefing should take place as soon as everyone has calmed down. It is not intended to be fault-finding. It is intended to help recover from the incident and to prevent a similar situation in the future. It is an opportunity for everyone to talk about what they saw, heard, thought and felt. It is like putting a puzzle together, and everyone involved has a piece of the puzzle. Oftentimes you and your co-workers may feel confusion, disappointment, anger and fear over the incident. This is normal and to be expected. Help everyone talk about their feelings. Some folks may have difficulty discussing their feelings, and it may take some time to feel safe enough in the group to talk. The goal of this is to create a safe group for people to look clearly and carefully at what happened. If at all possible, the person receiving the physical restraint should be part of this process.

Some suggestions about where to begin are:

- Talk about what was going on just before anyone noticed a problem starting. Use your training in prevention and alternatives to aggression to assess the environment. Look at time of day, room temperature, noise levels, the manner of other people in the area. What was everyone doing?, etc.
- Talk about the person who became upset. What do you and your co-workers know about the person? (his/her daily routine, what he/she likes and does not like to do, what makes this person frightened, confused, or angry) How does this person react when he/she is upset? What did you and your co-workers notice about the person before the incident? (was he/she tired, not feeling well, angry at another person, wanting something)
- Talk about what happened. Ask each person to describe what they saw, heard, thought and felt as the incident began and what they did. Remember, you as a group are putting this puzzle picture of the incident together. Sometimes the smallest piece of information may be just what is needed. (such as the person was hungry and impatient to eat, he/she got upset



because there are loud noises and raised voices, the person was hearing voices that were frightening him/her, the person was made to do something they did not want to do.)

- Talk through what each person did. Examine each step of the incident and look for possible things that may have caused the incident to escalate, missed opportunities for calming the situation and how the techniques were performed.
- Finally, talk about what might be done in the future to prevent the incident from happening again. Look for solutions in the environment, the person, the people around the area and your co-workers. Any new information/understandings should be documented and shared with all co-workers who provide supports to the person. This should be shared with the person if at all possible. Maintaining a safe environment can often become a goal around which staff and person (s) supported/treated can form an alliance.

The designated staff should complete any forms or reports that are appropriate to document the incident.