Washington State Department of Social & Health Services

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: RESTRICTIVE PROCEDURES AND PHYSICAL INTERVENTIONS WITH CHILDREN AND YOUTH — POLICY 5.20

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TITLE: RESTRICTIVE PROCEDURES AND PHYSICAL INTERVENTIONS WITH CHILDREN AND YOUTH — POLICY 5.20

Authority:
Chapter 71A RCW - *Developmental Disabilities*
Chapter 388-101 WAC - *Certified Community Residential Services and Supports*
Chapter 388-148 WAC - *Licensing Requirements*
Chapter 388-825 WAC - *DDA Services Rules*
Chapter 388-826 WAC - *Voluntary Placement Services*
Chapter 388-845 WAC - *Home and Community Based Services Waivers*

Reference: DDA Policy 5.19*, Positive Behavior Support for Children and Youth*

BACKGROUND

When a child or youth's behavior presents a threat of injury to self or others or significant damage to property, steps must be taken to protect the child/youth and/or others from harm, or to prevent significant property damage. It is expected that supports as described In the Developmental Disabilities Administration (DDA) Policy 5.19, *Positive Behavior Support for Children and Youth*, will be used to reduce the challenging behaviors and to eliminate the need for restrictive practices. When positive behavior support alone is insufficient, procedures that involve temporary restrictions or use of physical intervention may be necessary.

PURPOSE

This policy describes the Administration's expectations regarding the use of restrictive procedures and physical interventions with children and youth who have challenging behaviors. The policy describes which restrictive procedures and physical interventions are allowed and which are prohibited, the circumstances under which allowed restrictive procedures and physical interventions may be used, the requirements that must be met before they may be used, and the requirements for documenting and monitoring their use.

For specific information and requirements regarding the development and implementation of functional behavioral assessments and positive behavior support plans, refer to DDD Policy 5.19, *Positive Behavior Support for Children and Youth*.

SCOPE

This policy applies to children and youth who receive the following DDA funded services:

A. Licensed Children's Residential Services (up to age 21 years), including:

1. Child Foster Homes;

2. Group Care Facilities including Staffed Residential Homes;

3. Contracted Behavior Support and Consultation Providers used in the settings described above; and.

4. Agency consultants providing behavior support and consultation services.

B. For children and youth up to age 18 years of age, Behavior Support and Consultation services from contracted providers working with non-CIIBS (Children's Intensive In-home Behavioral Support Program) participants in the family home.

C. Residential habilitation services in a Children's State-Operated Living Alternative.

DEFINITIONS

Aversive stimulation means the application of a stimulus that is unpleasant to the child/youth (e.g., water mist to the face, unpleasant tastes applied directly to the mouth, noxious smells, etc.). *This procedure is prohibited.*

Challenging Behavior means actions by the child/youth that constitute a threat to the child/youth's health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the child/youth's functioning in public places and integration with the community, or uncontrolled symptoms of a physical or mental condition. These behaviors may have been present for long periods of time or have manifested as an acute onset.

Child/Youth means age three (3) up to 21 years. For Children's Residential Services, "youth" refers to individuals age 18 up to 21 years.

Corporal punishment means physical punishment of any kind. *This is prohibited.*

Electric shock means the application of an electric current or charge to any part of the body. *This procedure is prohibited*.

Emergency means an extreme hazard or an unanticipated, unpredicted action by a child/youth, that presents an immediate risk to the health and safety to self, others, or property (e.g., when a child/youth is standing or sitting in the street or at immediate risk of danger from a fire).

Exclusionary Time Out means the removal of a child/youth from a situation where positive reinforcement is available to an area where it is not, contingent on the occurrence of a specific behavior. This means a room used solely for the purpose of time out and where exiting the area is prevented. *This procedure is prohibited.*

Forced compliance means using physical force to get a child/youth to do something he/she does not want to do. *This procedure is prohibited.*

Locking a child/youth alone in a room means egress is not possible. *This procedure is prohibited.*

Mechanical restraint means applying a device or object, which the child/youth cannot remove, to the child/youth's body that restricts his/her free movement.

Overcorrection means requiring a child/youth to clean or fix the environment more than necessary to restore it to its original state, and/or to repeatedly practice the correct way to do something as a consequence for having done something wrong. *This procedure is prohibited.*

Physical intervention means the use of a manual technique intended to interrupt or stop a behavior from occurring. Physical intervention includes using physical restraint to release or escape from a dangerous or potentially dangerous situation.

Physical restraint means physically holding or restraining all or part of a child/youth's body in a way that restricts the child/youth's free movement. This does not include briefly holding, without undue force, a child/youth in order to calm him/her, or holding a child/youth's hand to escort the child/youth safely from one area to another or using seatbelts for wheelchair safety.

Physical or mechanical restraint in a prone position means the child/youth is being restrained while lying on his/her stomach. *This procedure is prohibited.*

Physical restraint in a supine position means the child/youth is being restrained while lying on his/her back. *This procedure is prohibited.*

Restrictive procedure means a procedure that restricts a child/youth's freedom of movement, restricts access to the child/youth's property, requires a child/youth to do something which he/she does not want to do, or removes something the child/youth owns or has earned.

Video monitor means any type of type of device used to visually monitor a person or area. This includes standard video monitors and recording devices, closed circuit monitors, cell phones with video capabilities, Wi-Fi cameras, and web enabled cameras, such as those available/accessible through a computer.

POLICY

A. **The use of restrictive procedures with children and youth requires consideration of their developmental level and careful evaluation and oversight.** Some procedures that would be restrictive for an adult and by policy might require an Exception to Policy (ETP) may not require an ETP when used with children and youth.

For example, restricting a child/youth's access to certain populations, areas, or public places is developmentally appropriate. Adults acting in lieu of a parent are expected to supervise children/youth with regard to their safety.

B. Restrictive procedures must be used only as provided for in this policy.

C. Physical interventions must be used according to an approved Positive Behavior Support Plan (PBSP) and only when positive or less restrictive techniques or procedures have been tried and determined to be insufficient to protect the child/youth, others, or to prevent significant property damage. Unless the child/youth's behavior poses an immediate risk to physical safety, efforts other than physical restraint must be used.

Licensed residential settings must adhere to Chapter 388-128 and 388-145 WAC in addition to this policy. When a child/youth's PBSP includes restrictive procedures that may impact his/her housemates, efforts must be made to minimize the effect on the housemates. How the housemates will manage these restrictions must be documented in their respective service plans.

D. Restrictive procedures and physical interventions as described in this policy may be used for the purpose of protection and to teach the child/youth natural consequences for engaging in challenging behavior. Restrictive procedures may not be used for the purpose of changing behavior in situations where no need for protection is present. Protective restrictive procedures have one or more of the following characteristics:

1. Interrupting or preventing behaviors that are dangerous or harmful to the child/youth or others;

2. Interrupting or preventing behaviors that cause significant emotional or psychological stress to the child/youth or others; or

3. Interrupting or preventing behaviors that may result in significant damage to the child/youth's property or that of others.

E. The least restrictive procedures needed to adequately protect the child/youth, others, or property must be used. Restrictive procedures must be terminated as soon as the need for protection is over.

F. If the PBSP includes restrictive procedures as defined or described in DDA policy, it must also contain:

1. A description of the restrictive procedure that will be used, when and how it will be used, and clear criteria for termination;

2. A plan for recording data on the use of the procedure and its effect (each use of the restrictive procedure must be documented); and

3. A description of how the program, interdisciplinary team (IDT), or contracted provider will monitor the PBSP, assess restrictive procedure outcomes against criteria for termination, and determine whether there is a continued need for the restrictive procedure.

PROCEDURES

A. Identifying the Need for Restrictive Procedures and Physical Interventions

Before implementing restrictive procedures and physical interventions, the parent/guardian (and the youth, as appropriate) must be involved in discussions regarding the perceived need for these methods, including:

1. The specific restrictive procedures and physical interventions to be used;

2. The perceived risks of both the child/youth's challenging behavior and the restrictive procedures and physical interventions;

3. The reasons which justify the use of the restrictive procedures and physical interventions; and

4. The reasons why less restrictive methods are not sufficient.

B. Prohibited Procedures

1. In addition to the prohibited procedures listed below, providers in licensed residential settings must adhere to Chapter 388-148 and 388-145 WAC which also specifies prohibited disciplinary procedures. This also applies to Section D below.

2. **Procedures that are not permitted under any circumstances** and for which no exceptions to policy (ETP) shall be granted are listed below:

a. Corporal/physical punishment;

b. The application of any electric shock or stimulus to a child/youth's body;

c. Forced compliance, including exercise, when it is not for protection;

d. Locking a child/youth alone in a room;

e. Exclusionary Time Out (see Definitions section);

f. Overcorrection;

g. Physical or mechanical restraint in a prone position where the child/youth is laying on his/her stomach;

h. Physical restraint in a supine position where the child/youth is lying on his/her back;

i. Removing, withholding, or taking away money, tokens, points, or activities that a child/youth has previously earned;

j. Requiring a child/youth to re-earn money or items purchased previously;

k. Withholding or modifying food as a consequence for behavior (e.g., withholding dessert because the child/youth was aggressive);

l. Restraint chairs; and

m. Restraint boards.

C. **Prohibited Physical Interventions**

1. Physical interventions using any of the following are **not permitted under any circumstances** and no exceptions to policy (ETP) for their use shall be granted.

a. Any intervention that causes pain to the child/youth and/or uses pressure points (whether for brief or extended periods);

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

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

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

e. Direct physical contact covering the face;

f. Straddling or sitting on the torso;

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

h. Any maneuver that involves punching, hitting, slapping, poking, pinching or shoving the child/youth.

2. **The following specific physical techniques are prohibited:**

a. Arm or other joint locks (e.g., holding one or both arms behind back and applying pressure, pulling or lifting);

b. A "sleeper hold" or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;

c. Wrestling holds, body throws or other martial arts techniques;

d. Prone restraint (child/youth lying on the stomach);

e. Supine restraint (child/youth lying on the back);

f. A head hold where the child/youth's head is used as a lever to control movement of other body parts;

g. Any maneuver that forces the child/youth to the floor on his/her knees or hands and knees;

h. Any technique that keeps the child/youth off balance (e.g., shoving, tripping, pushing on the backs of the knees, pulling on the child/youth's legs or arms, swinging or spinning the child/youth around, etc.); and

i. Any technique that restrains a child/youth face-first vertically against a wall or post.

D. Use of Bed Side Rails for Children in Licensed Settings

1. Bed side rails are known to present a potential risk of harm in the form of entrapment, injury, and death. This potential exists for all rails, whether they are full, half, or quarter rails. Consequently, the use of rails requires monitoring for ongoing need for continued use. A PBSP is not required; however, there must be a written instruction plan (see section 4. below).

2. Under no circumstances can the side rails be used for staff convenience or to purposely restrain a child unnecessarily.

3. Side rails are permitted **when medically necessary** for the child's health and safety, provided the following requirements are met:

   a. There is a current physician's order that clearly states the reason and justification for use of the side rails; and

   b. The child's legal representative must be made aware of the side rail use and give consent for its use. The service provider must send a copy of the signed consent form to the CRM/SW/SSS for inclusion in the client record.

4. There is a written instruction plan that gives direction to all residential staff regarding how to properly operate and lock the side rails and monitor them to ensure they work correctly. The plan should be updated and assessed annually for need for continuation. Instructions of the plan must include:

   a. Checking that the mattress fits tightly against the side rail;

   b. For clients unable to reposition themselves, position changes are done no less than once every two (2) hours during waking hours (and at night if the prescriber requests); and

   c. Frequent bed checks for safety and well-being during awake hours are conducted at a higher frequency than repositioning. The plan must state the frequency of bed checks.

5. Additional safety information regarding bed rails may be found at: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/MedicalToolsandSupplies/HospitalBeds/default.htm.

E. Restrictive Procedures and Physical Interventions Permitted with a PBSP

The restrictive procedures and physical interventions listed below require a PBSP as specified in this policy (see also DDA Policy 5.19, *Positive Behavior Support for Children and Youth,* which also lists certain protective procedures that require a PBSP). Protective restrictive procedures include, but are not limited to:

1. Requiring a child/youth to leave an area with physical force (i.e., physically holding and moving the child/youth) for protection of the child/youth, others, or property.

2. Physical restraint to prevent the free movement of part or all of the child/youth's body when the child/youth's behavior poses an immediate risk to physical safety. **Restraint in a prone or supine position (i.e., with the child/youth lying on the stomach or back, respectively) is prohibited.** See also Chapter 388-148 and 388-145 WAC for requirements for licensed residential settings.

3. Mechanical restraint that limits the child/youth's free movement or prevents self-injurious behavior (e.g., a helmet for head-banging, hand mittens or arm splints for biting, etc.). See also Chapter 388-148 and 388-145 WAC for requirements in licensed residential settings.

   a. A current written order from a physician or an Advanced Registered Nurse Practitioner (ARNP) order is required for use of all mechanical restraints.

   b. **Mechanical restraint in a prone position (lying on the stomach) is prohibited.**

   Note: Splints applied for purposes of physical therapy or other mechanical devices used to maintain proper body posture, wheelchair safety (e.g., seat belts or chest straps), and medically necessary devices used to protect a child/youth from accidental injury (e.g., helmets for children and youth with seizures, gait belts, vehicle safety harness, etc.) or the use of car door locks for safety purposes are not considered restrictive procedures and do not require a PBSP unless there is a behavioral component.

4. Specific protective physical interventions include, but are not limited to:

   a. Hand, arm, and leg holds;

   b. Standing holds;

   c. Physically holding and moving a child/youth who is resisting; and

   d. Head holds.

   Note: Physical control of the head is permitted only to interrupt biting or self-injury such as head banging.

F. **Restrictive Procedures and Physical Interventions Permitted Only By Exception to Policy (ETP)**

The procedures listed below are considered extremely intrusive and may be used only when less intrusive procedures have failed to protect the child/youth, others, or property. **Use of these procedures requires a PBSP and an ETP.**

1. Approval at the Deputy Assistant Secretary Level

The following restrictive procedure requires the prior written approval of the Deputy Assistant Secretary:

Use of ongoing video monitoring for medical necessity for more than six (6) months in a licensed residential setting. See Section 2.f below for complete requirements.

2. Approval at the Regional Administrator Level

The following restrictive procedures require the prior written approval of the DDA Regional Administrator:

a. **Controlling food consumption** for children and youth who have behavioral issues related to unrestricted access to food (such as stealing food, running away to get food, being assaultive when denied food, etc.):

1. When a long-term threat exists to the child/youth's health, as determined in writing by a physician, such as the need for a specialized diet (see also Chapter 388-148 and 388-145 WAC).

2. When a short term threat exists, such as eating raw meat, uncontrolled intake of water, etc.

3. An ETP is required whenever a client's food or kitchen is locked up and not accessible to the client.

b. **Use of either of the following physical restraint interventions**:

1. Child/youth seated on furniture (e.g., a couch) and physically restrained by two persons sitting on either side (Note: This procedure involves the use of a supported guide); and

2. Child/youth sitting on the floor and being physically restrained by one or more persons (Note: This procedure involves the use of a supported guide).

3. The physical restraints described above in 1 and 2 may be used only as part of an approved physical intervention system/curricula.

4. As part of the approval process, there must be a written assessment by a physician or an ARNP that states the physical restraint to be

used is not contraindicated for the child/youth due to physical or other medical conditions.

c. **Requiring a child/youth to carry or wear any electronic monitoring device on his/her body to monitor the child/youth's behavior**, including global positioning system (GPS) devices, or other devices such as cellular phones with GPS tracking capabilities, for eloping or wandering.

d. **Regulating or controlling a youth's (age 18-21) money in a manner that the youth and/or parent/guardian object t**o. **Note**: Providing an allowance to the child/youth for weekly spending money is not considered restrictive Chapter 388-148 and 388-145 WAC.

e. **The use of locks on doors, gates, and fences** for children and youth who frequently elope or wander away and which prevent **independent** egress from the residence and/or yard. Exit doors and rescue windows must be easily and quickly opened from the inside without requiring a key or special instruction. Providers must adhere to Chapter 388-148 and 388-145 WAC.

f. **The use of vehicle seat belt buckle locks or guards** for children and youth who pose a danger to themselves or others by not remaining in their seat in a moving vehicle.

g. **Use of video monitors for client health and safety**

1. All people have the right to privacy, including children and youth. The use of a video monitor in a child/youth's home or bedroom is extremely intrusive. For this reason, there must be tight controls around the use of video monitors and ongoing assessment of the need for their continued use. See Definitions section regarding video monitors.

2. Video monitors are permitted when medically necessary for the child/youth's health and safety, provided the following requirements are met:

a) There is documentation that the child/youth's interdisciplinary team, including the CRM/SW/SSS and residential services staff, has explored other less invasive options (e.g., additional staffing, installing call buttons, bed alarms, motion sensor, etc.) prior to requesting to use a video monitor.

b) There is a current written order from a physician or an ARNP that clearly states the reason and justification for the video monitoring of the child/youth and anticipated duration of monitor use.

c) The child/youth and his/her parent or guardian must be aware of the monitor and give consent for its use. Their signed consent must be documented in the client record.

d) There is a written plan that gives direction to all residential staff regarding:

i. When the monitor is to be turned on and off;

ii. Consideration of privacy issues;

iii. How to respond when the child/youth turns off the monitor;

iv. No video recording is permitted;

v. Documentation requirements;

vi. Under no circumstances can the video monitor be used for staff convenience or to purposely invade a child/youth's privacy; and

vii. Staff responsible for viewing the monitor will receive training on this plan.

e) There is an approved ETP as follows:

i. If the monitor will be used for six (6) months or less, the Regional Administrator (RA) will be the approving authority; **or**

ii. If it is anticipated that the monitor will be used for more than six (6) months, the Deputy Assistant Secretary will be the approving authority.

f) Staff will document the use of the monitor, including duration and name of staff, on a daily basis. This data must be included in the client record.

G. **Emergency Use of Restrictive Procedures and Physical Interventions**

1. "Emergency" means an extreme hazard or an unanticipated, unpredicted action by a child/youth, that presents an immediate risk to the health and safety to self, others, or property (e.g., when a child/youth is standing or sitting in the street or at immediate risk of danger from a fire).

2. In an emergency, procedures and physical interventions normally permitted only with an approved PBSP may be used for protective purposes.

3. The least restrictive procedures and physical interventions must be used and must be terminated as soon as the need for protection is over.

4. Providers must submit an incident report to the DDA CRM/SW/SSS for each emergency use of restrictive procedures and physical interventions in accordance with procedures for reporting incidents (see section H below).

5. If the same restrictive procedure or physical intervention is used on an emergency basis more than three (3) times within a six (6) month period, a functional assessment must be conducted and a PBSP developed and implemented within sixty (60) days.

H. **Incident Reports**

Incident reports are required under the following conditions:

1. When any injuries are sustained by any child/youth during implementation of a restrictive procedure or physical intervention; and

2. Whenever restrictive procedures or physical interventions are implemented under emergency guidelines. These incidents must be reported within one business day per DDA Policy 6.12, *Mandatory Reporting Requirements for Residential Services Provider, Attachment B: Reporting Timelines.*

3. For children/youth in licensed residential settings, see Chapter 388-148 and 388-145 WAC regarding reporting incidents in which a restrictive procedure or intervention was used.

I. **Data Monitoring of Restrictive Procedures and Physical Interventions**

1. Program or behavioral staff responsible for developing the PBSPs must review the plan and data collected at least every thirty (30) days.

2. If the data indicates no changes in decreasing the challenging behaviors for three (3) months, but no later than six (6) months, the provider must review and amend the FA and PBSP and implement the revised plan.

3. At least annually, the approving authorities must re-approve restrictive procedures that require ETPs or involve physical or mechanical restraint.

J. **Implementation of Physical Interventions**

1. All residential service providers must have documentation of prior training in the use of such techniques. With all training on the use of physical interventions, providers must also receive training in crisis prevention techniques, positive behavior support, and observation and supervision of physical restraints (e.g., signs of duress, fatigue, etc.). See Chapter 388-148 and 388-145 WAC for training requirements for licensed residential settings.

2. A post-analysis (i.e., a debriefing to review the incident and assess what could have been done differently) must take place whenever restrictive physical interventions are implemented in emergencies **or** when the frequency of use of the intervention is increasing. The child/youth, service providers involved, supervisor (in residential settings), parent/guardian, and other team members must participate, as appropriate.

3. The CRM/SW/SSS must document the post-analysis in a service episode record (SER) in the client record.

K. **Components of a Physical Intervention Techniques System**

DDA requires that any physical intervention techniques system used by a contracted service provider contain certain components. These requirements are described in Attachment A, *Necessary Components of a Physical Intervention Techniques System.*

1. Providers receiving physical intervention techniques training must complete the course of instruction and demonstrate competency before being authorized to use the techniques with children and youth; and

2. A review of de-escalation techniques and physical intervention techniques with all service providers and members of the child/youth's support team must occur annually before continuing to be used with the child/youth.

EXCEPTIONS

A. The agency, service provider, or other treatment professional requesting an exception to policy (ETP) must complete DSHS 02-556, *Request for Exception to Policy for Use of*

Restrictive Procedures, and send the completed form with all its attachments to the CRM/SW/SSS. A signed consent form must accompany the request (See DSHS 15-385, *Consent for Use of Restrictive Procedures Requiring an ETP*).

B. Upon receipt of the ETP request packet, the CRM/SW/SSS will initiate the Restrictive Procedures ETP request in the Comprehensive Reporting and Assessment Evaluation (CARE) application as follows:

1. Choose the ETR/ETP Category – Restrictive Procedures;

2. Choose ETR/ETP Type – Restrictive Procedures;

3. Choose Related Assessment;

4. Choose Date Range: Custom or Plan Period, as appropriate;

5. Enter Request Description:

   a. Describe the behaviors for which the restrictive procedure ETP is being requested;
   b. Describe in one or two sentences the restrictive procedure ETP being requested;

   c. Type the following: "Refer to request packet in file dated _____."

6. Enter Justification for Request: "See request packet."

7. Enter Alternatives Explored: "See request packet."

8. Process to next level of review/approval based on the regional process.

9. Print copy of ETP and attach to request packet for reviewer/approver.

C. ETPs for restrictive procedures must be reviewed and approved or denied in writing by the Regional Administrator or designee within fifteen (15) calendar days after receipt of the request and required documentation.

D. ETPs for use of restrictive procedures that require approval at the Deputy Assistant Secretary level must first be approved by the DDA Regional Administrator and forwarded to the Deputy Assistant Secretary for a decision prior to implementation.

E. No exceptions for the use of prohibited physical interventions as described in this policy shall be granted.

F. Any other exceptions to the requirements of this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESSION

DDD Policy 5.20
Issued January 3, 2012

Approved: */s/ Janet Adams for Donald Clintsman* Date: November 15, 2014
Deputy Assistant Secretary
Developmental Disabilities Administration

Attachment A, *Necessary Components of a Physical Intervention Techniques System*

NECESSARY COMPONENTS OF A PHYSICAL INTERVENTION TECHNIQUES SYSTEM

Physical intervention systems must include, at a minimum, the following training components:

1. Principles of positive behavior support, including respect and dignity;

2. Communication techniques to assist a child/youth to calm down and resolve problems in a constructive manner;

3. Techniques to prevent or avoid escalation of behavior prior to physical contact;

4. Techniques for providers and parents/guardians to use in response to their own feelings or expressions of fear, anger, or aggression;

5. Techniques for providers and parents/guardians to use in response to the child/youth's feelings of fear or anger;

6. Instruction that physical intervention techniques may not be modified except as necessary in consideration of individual disabilities, medical, health, and safety issues. An appropriate medical/health professional and a certified trainer or behavioral specialist must approve all modifications;

7. Evaluation of the safety of the physical environment at the time of the intervention;

8. Use of the least restrictive physical interventions depending upon the situation;

9. Clear presentation and identification of prohibited and permitted physical intervention techniques as outlined in this policy;

10. Discussion of the need to release a child/youth from physical restraint as soon as possible;

11. Instruction on how to support physical interventions as an observer and recognize signs of distress by the child/youth and fatigue by the staff; and

12. Discussion of the importance of complete and accurate documentation by service providers.