

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD)

DIRECTOR'S RELEASE (DR)

EFFECTIVE DATE: August 10, 2010

Signature Date:	August 3, 2010
FROM:	Signature on file Mikki Rogers, DDS D Director
TO:	All providers and DDS D staff
SUBJECT:	A new guideline that identifies the roles and responsibilities of provider agency administration and direct support staff regarding the reporting and monitoring of emergency physical restraints

I. SUMMARY:

This Director's Release describes procedures to ensure that every individual participating in Medicaid Waiver and State General Funded services supported through the Developmental Disabilities Support Division (DDSD) is free from the unnecessary use of restrictive physical crisis intervention measures. This release also describes procedures to maximize safety when emergency physical restraint must be used to ensure basic health and safety.

II. SPECIFIC SECTION OF THE REQUIREMENT AFFECTED BY THIS RELEASE:

This Director's Release will amend Chapter 1, Section II of the DD Waiver Standards by adding a new subsection H that will address the use of emergency physical restraint.

III. Requirement Amendment(s) or Clarifications

This Director's Release applies to every individual participating in or working for the Medicaid Waiver and State General Fund services supported through the DDSD.

It is the policy of DDSD:

To promote practices that reduce and ultimately strive to eliminate the use of emergency physical restraint.

To provide procedures that address the use of physical intervention and emergency physical restraint only in crisis situations that have, or imminently may evolve into an emergency.

To have the Office of Behavioral Services (OBS) review and approve all provider agency policies and procedures that include the use of emergency physical restraint.

To allow the use of emergency physical restraint as a last resort only when other less intrusive alternatives have failed and under limited circumstances that include:

1. To protect an individual, peer, staff, or member of the community from imminent, serious physical harm.
2. To prevent or minimize any physical and/or emotional harm to the individual during an emergency physical restraint.

Specific circumstances where the use of emergency physical restraints is permitted include:

1. The intervention is deemed necessary to prevent behavior that poses a threat of imminent, serious physical harm to self and/or others, or:
2. The intervention is deemed necessary to prevent behavior that will result in extreme property damage that would subsequently create a health and safety hazard,
3. When non-physical interventions and de-escalation strategies have been exhausted and the threat of imminent, serious physical harm persists, and;
4. The emergency physical restraint shall be discontinued as soon as the safety of all individuals in the immediate area is assured. As such, the intervention is event rather than time based, except where prohibited by the agency approved protocol of crisis prevention and intervention,
5. Discontinuing the emergency physical restraint is determined by interveners at the earliest, safe opportunity to do so.

To endorse the use of the least intrusive intervention necessary to assure health and safety.

To require a written individualized Behavioral Crisis Intervention Plan (BCIP) to include specific guidelines and criteria for implementing emergency physical restraint.

To permit the use of emergency physical restraint in the absence of a BCIP under the exceptional occasion when an individual presents extreme unique, unprecedented and unpredicted behavior that requires immediate physical intervention.

To require a Human Rights Committee (HRC) review of any BCIP that includes the use of emergency physical restraint.

To prohibit the continued, long-term use of emergency physical restraint as a substitute for on-going positive support.

The use of emergency physical restraint is prohibited under the following conditions:

1. Physical restraint used as a programmatic contingent punishment;
2. As a cost response to:
 - a. property destruction or program disruption,
 - b. an individual's refusal to comply with a rule or staff directive,
 - c. verbal threats, or
 - d. other disruptive behavior that does not constitute a threat of imminent, serious, physical harm.
3. The use of mechanical restraint as an intervention for behavioral emergencies. (The Protective Stabilization and Medical Immobilization policy allows protocols, including mechanical devices, explicitly authorized by a physician or dentist during specific medical procedures and is a related, but separate consideration.)
4. The use of seclusion, isolation, chemical restraint, and supine and prone floor restraints.

To have a protocol for the proper administration of an emergency physical restraint. (Refer to Section V. Roles and Responsibilities for procedures for administration of Emergency Physical Restraint.)

To require pre-service training and physical crisis prevention and intervention training for those staff who may be or are assigned to support individuals who may exhibit behavior potentially requiring physical intervention and/or emergency physical restraint to maximize safety. (Refer to Section V. Roles and Responsibilities for procedures for training regarding Emergency Physical Restraint.)

To have a protocol for the proper recording and reporting of emergency physical restraint use. (Refer to Section V. Roles and Responsibilities for procedures for reporting and monitoring of Emergency Physical Restraint.)

IV. Definitions:

Behavioral Crisis Intervention Plan: Means a document usually developed by the Behavior Support Consultant in collaboration with the members of the interdisciplinary team (IDT) that provides guidance to staff when an individual has a challenging behavior that has the potential to escalate to a severity level posing great risk of harm to the individual or others. All staff must be trained on all Behavioral Crisis Intervention Plans for the individuals they support. Each Behavioral Crisis Intervention Plan shall be written in simple terminology.

Cognitive Behaviorism: Means a conceptual model for learning that identifies many internal mental activities, referred to as cognitive maps, which influence behavior beyond positive or negative reinforcement. The maps encode constructs of self, situations, and others; expectancies including an assessment of one's ability to perform, consequences, past performance, and meaning; emotional and physiological responses; goals and values; cognitive competencies including knowledge and skills; and plans for self-regulation that include achievement strategies and management of internal emotional states.

Chemical restraint: Means the administration of medication at a dose and/or frequency to intentionally and exclusively preclude behavior without identifying an underlying anxiety, fear or severe emotional distress or other symptoms of psychiatric/emotional disturbance to be eased, managed and/or treated. The administration may be regularly scheduled or on an "as needed" PRN basis.

Cost response: Means a designed, intentionally punitive consequential response to behavior that intends to preclude or reduce future similar behavior by extracting a "payment" from an individual without an accompanying teaching of an alternative functional substitute.

De-escalation: Means verbal and non-verbal interactions intended to lessen the setting factors contributing to an individual's distress and/or assist them in reducing distress and regaining emotional balance.

Decompression/Resolution protocols: Means procedures designed to restore emotional and attitudinal stability following an event that evokes distress and threatens to undermine supportive relationships.

Emergency physical restraint: Means the use of personal, manual physical force to limit, prohibit or preclude imminently dangerous behavior by restricting movement through specified and allowed sustained physical contact or holding procedures.

Environmental modifications or adaptations: Means changes to a physical setting such as seating arrangements, use and organization of space, participant density, adaptive equipment and tasks.

Extended emergency physical restraint: Means an emergency physical restraint administered for more than ten (10) minutes.

Imminent, serious physical harm: Means harm certain to result in physical insult great enough to render an individual incapable of continuing usual activities regardless of whether medical intervention is needed.

Mechanical Restraint: Means the use of a physical device to restrict the individual's capacity for desired or intended movement including movement or normal function of a portion of his or her body.

Physical intervention: Means the use of touch and/or brief physical redirection with minimal physical force to guide or direct an individual from danger or as an adjunct to instruction. Physical intervention changes the direction of movement rather than stopping or preventing movement.

Physical redirection: Means the use of touch and/or body position with minimal physical force to redirect attempts by an individual to strike or otherwise cause physical insult or harm.

Precursors: Means physiological indications of emotional arousal which are indicative of distress. These may include, but are not limited to, increased motor agitation, facial flushing, and dilated pupils.

Programmatic restraint: Means the planned use of restraint in non-emergency situations intended as punishment for undesirable behavior.

Seclusion and Isolation: Means physically and/or coercively confining an individual alone in a room or limited space. This applies whether the setting is mechanically locked or forcibly contained by other means. This does not include limiting access to specifically identified areas such as housemate bedrooms or any areas deemed unsafe such as closets with cleaning solvents. This also does not eliminate an individual's preference to spend time alone.

Self-protective behavior: Means certain actions taken to assure personal safety during a crisis. This may include using one's hands or arms to block attempted blows, employing grasp release strategies identified in approved crisis intervention protocols, or the use of pillows or other soft materials to absorb impact.

Setting factors: Means interpersonal, intrapersonal, environmental and activity considerations that "set the stage" for emotional distress and subsequent behavioral expression. Setting factors are included as broad considerations of antecedents and precursors to behavior.

Social Learning Theory: Means a conceptual model for learning as a result of observing and imitating others without being linked to specific patterns of positive or negative

reinforcement. Rather, the learning process is represented by “efficacy” that assesses the quality, impact and purpose of actions against intended goals.

Supine and prone floor restraint: Means physical intervention techniques that intentionally place and hold an individual lying either face up (supine) or face down (prone) on the floor.

V. Roles and Responsibilities: The Developmental Disabilities Support Division (DDSD)/Office of Behavioral Services (OBS), Support Consultants, Interdisciplinary Team, provider agency administration and direct support staff, Case Managers, and Human Rights Committees, regarding the training, implementation, and reporting and monitoring of emergency physical restraints.

A. The Developmental Disabilities Supports Division/Office of Behavioral Services (DDSD/OBS):

1. Provides training and technical assistance based on:
 - a. Positive Behavioral Support applying principles of Cognitive Behaviorism and Social Learning Theory;
 - b. An evolving understanding of authentic person-centered support;
 - c. A clearly articulated policy regarding the limited circumstances and required conditions under which any emergency physical restraint may be employed; and,
 - d. The constitution and oversight activities of Human Rights Committees.
2. Distributes Behavior Support Consultation Practice Guidelines that inform Behavior Support Consultation practice and associated Positive Behavior Supports Plans and Behavioral Crisis Intervention Plans (BCIP).
3. Provides on-going training and technical assistance contributing to Positive Behavior Support and decreased use of emergency physical restraint.
4. Reviews provider agency requests for crisis intervention protocols not currently authorized. The OBS Director or his/her designee will review a detailed written description of the protocol and attend demonstration training on the alternative approach. A decision for approval, disapproval and/or modification will result. Any modifications will be negotiated between the protocol authors and pertinent providers. The Mandt System is currently approved. Handle with Care and the Crisis Prevention Institute’s (CPI) Nonviolent Crisis Intervention protocols are currently approved in modified form. (The modifications to both protocols eliminated the use of interventions determined to present heightened risk of physical harm to the individual and/or intentionally employ pain as a deterrent.)
5. Designates and convenes an Emergency Physical Restraint Review Committee to review and analyze the use of emergency physical restraint. The Committee will consider individual, agency, and regional factors in the review. The Committee will consider whether the emergency physical restraint satisfied the required goals, allowed uses, prohibitions, and proper administration requirements cited in the Emergency Physical Restraint Policy. The committee will convert individual and agency information into usable data for aggregate analysis to:
 - a. Identify systemic issues that sustain the use of emergency physical restraint and develop solutions to correct those issues.

- b. Identify prevention/intervention strategies that are absent or inconsistently applied.
 - c. Identify training and/or technical assistance initiatives to reduce recurrent use of emergency physical restraint.
 - d. Identify recommendations and strategies that promote on-going efforts to assure the health, welfare, rights, and respectful support of individuals receiving support.
6. The Committee will determine if additional action is warranted following a report of:
- a. An injury or other reportable critical incident to the individual, and/or;
 - b. An extended emergency physical restraint, and/or;
 - c. Injury to intervening staff, and, if so, shall notify the program of any required actions within 14 calendar days of receipt of the required written report(s).

B. Behavior Support Consultant

1. Provides initial and on-going training regarding the Positive Behavior Supports and behavioral Crisis Prevention/Intervention Plans.
2. Identifies individualized criteria and thresholds for amending and/or retraining the Positive Behavioral Supports and behavioral Crisis Prevention/Intervention Plans.
3. Explores with Interdisciplinary Team (IDT) input the potential that an individual receiving support services may exhibit behavior defined as an emergency that compromises the health and safety of the individual or others.
4. Describes potential crisis events that may escalate to emergencies. A potential crisis situation that is anticipated, based on past episodes and planned for, whether or not there is a reoccurrence, may still escalate to an emergency situation.
5. Develops an individualized, written Behavioral Crisis Intervention Plan (BCIP) that includes effective intervention, at times including emergency physical restraint only as a last resort. The BCIP will include a hierarchy of intervention strategies designed to prevent emergency situations from escalating to harmful, injurious outcomes. Strategies evolve from but will exceed the prevention and intervention strategies in the Positive Behavior Supports Plan, and may include de-escalation of potentially overwhelming emotional distress.
6. Identifies and includes specific, written individualized criteria that guide staff decisions to employ emergency physical restraint.
7. Seeks consultation with and/or review of written records from the individual's physician, agency nurse and other involved medical personnel to identify medical or psychological limitations that heighten the potential for trauma during an emergency physical restraint. Any resulting cautions and/or contraindications will be noted in the BCIP.
8. Considers changes and/or amendments to the Positive Behavior Supports Plan that may preclude a similar crisis from occurring. Emergency physical restraint is not an acceptable substitute for thoughtful and thorough support and specific proactive strategies and shall be used with extreme caution.

9. Collaborates with the IDT to decrease continued, long-term need to use emergency physical restraint. Intensive efforts to reduce dependence on emergency physical restraint are expected whether or not the presenting behavior of concern is recently emerging or has deep historical roots in past trauma or physiological/syndromal factors.
10. Participates in and develops or revises the BCIP in conjunction with the IDT in the event of an unprecedented use of emergency physical restraint. A draft plan is expected within two business days of the emergency IDT. Behavioral Crisis Intervention Plans recommending emergency physical restraints and/or other rights restrictions will be submitted to the Human Rights Committee (HRC) for review.
11. Participates in post incident analysis following episodes resulting in the use of emergency physical restraint. The analysis intends to identify factors contributing to the incident and potential prevention and/or early intervention strategies to reduce the likelihood of a similar incident and preclude the use of emergency physical restraint.
12. Maintains a record of reported incidents of emergency physical restraint and includes reporting and analysis in Quarterly Reports submitted to the OBS and the individual's Case Manager.

C. Interdisciplinary Team

1. Participates in training regarding the Positive Behavior Supports Plan, behavioral Crisis Prevention/Intervention Plan and requirements for Human Rights Committees.
2. Considers changes to any aspect of the individual's support that is determined necessary to preclude a similar crisis and amend the Individual Service Plan accordingly.
3. Participates in an emergency IDT meeting following an unprecedented use of emergency physical restraint. The emergency IDT is expected to be convened within one business day to: 1) examine the factors contributing to the crisis, 2) explore alternative interventions that may have been used, 3) assess whether the contributing factors persist, and 4) attempt to predict if the presenting behavior is likely to recur and recommend additional or amended prevention and early intervention strategies.

D. Provider Agency Administration

1. Documents that staff receive all pre-service training required by DDSD.
2. Documents that staff has received training in the agency for approved crisis intervention protocol. The training must precede assignment to support individuals who by recent history exhibit behavior that may necessitate physical intervention and/or emergency physical restraint to maximize safety.
3. Documents that staff have received training in each individual's BCIP and are able and willing to implement the full hierarchy of interventions.
4. Establishes timelines and methods to provide staff with training regarding emergency physical restraint and agency policies and procedures prior to assignment where

- physical intervention and/or emergency physical restraint may be necessary. Training shall include information on the following:
- a. Interventions that may preclude the need for emergency physical restraint, including early identification and de-escalation of problematic behaviors and environmental modifications or adaptations, adjustments to staff interactions, and changes in activities and schedules that are more suited to the individual.
 - b. Types of emergency physical restraints and related safety considerations, including information regarding the increased risk of injury when an extended restraint is used.
 - c. Administering emergency physical restraint in accordance with known medical or psychological limitations that place the individual at greater than usual risk of compromised health or emotional status.
 - d. Reasonable actions staff may take as means to protect individuals, other persons, or themselves from assault or imminent, serious physical harm.
5. Provides or secures access to crisis prevention and intervention training for the identified agency resource staff. Crisis prevention and intervention training, including the use of emergency physical restraint, shall include, but not be limited to:
- a. Identifying appropriate procedures for preventing the need for emergency physical restraint, including the de-escalation of problematic behavior and emotional distress, relationship building and the use of alternatives to emergency physical restraint including adaptations to environments and activities.
 - b. A description and identification of behaviors or other physiological precursors that are generally indicative of heightened emotional distress that may indicate the potential for a behavioral emergency.
 - c. Identifying specific behaviors or other physiological precursors that are specific to each individual the provider supports that are indicative of heightened emotional distress that may indicate the potential for a behavioral emergency or crisis.
 - d. Establishing methods for evaluating the risk of harm to an individual weighed against expected benefits in harm reduction for the purpose of evaluating whether the use of emergency physical restraint is warranted and justified.
 - e. The simulated experience of administering and receiving emergency physical restraint, instruction regarding the effect(s) on the individual restrained, including instruction on monitoring physical signs of distress and obtaining medical assistance.
 - f. Instruction regarding documentation and reporting requirements and investigation of injuries and complaints as determined by this Director's Release and other related standards and policies of the Department of Health.
 - g. Demonstration by participants of proficiency in administering emergency physical restraint shall be developed in accordance with training protocols or by agency determination. Proficiency criteria may be reviewed by Department of Health personnel.
6. Submits to the OBS for review and approval of any crisis intervention protocol not currently approved that addresses the use of emergency physical restraint.
7. Identifies staff authorized to serve as an agency-wide resource regarding crisis management, including emergency physical restraint. The identified staff will be responsible for monitoring staff training and competence to administer emergency physical restraint effectively. Identified staff will also contribute to restraint reduction efforts on an individual and agency wide basis.

8. Establishes methods for evaluating the risk of harm to an individual weighed against expected benefits in harm reduction for the purpose of evaluating whether the use of emergency physical restraint is warranted and justified.
9. Establishes and uses decompression/resolution protocols following an incident resulting in an emergency physical restraint. These protocols shall include the following:
 - a. Reviewing the incident with the individual, when appropriate and if it is unlikely to evoke additional distress, to address the setting factors and behavior that precipitated the restraint.
 - b. Reviewing the incident with the staff person(s) who administered the emergency physical restraint to discuss potential proactive alternatives, and/or prevention opportunities, and whether proper procedures were followed.
 - c. Consideration of whether any follow-up is appropriate for individuals who witnessed the incident.
 - d. Agencies may choose to offer post-incident counseling to any involved parties as deemed helpful.
10. Each use of an emergency physical restraint will be followed by a post incident analysis with staff conducting the restraint, an agency designated administrator, and the Behavior Support Consultant within three business days of the event. This must include an assessment of environmental, interpersonal, and activity setting factors that are found to contribute to the likelihood that the individual will exhibit behavior resulting in an emergency physical restraint.
11. The director or his/her designee shall maintain an on-going record of all reported instances of emergency physical restraint, which shall be made available for review by the Department of Health according to the Significant Events Reporting System.
12. The director of the agency or his/her designee shall verbally inform the individual's guardian of the emergency physical restraint as soon as possible, and by written report postmarked no later than three business days following the use of restraint.
13. The director of the agency or his/her designee shall verbally inform the individual's Behavior Support Consultant of the restraint as soon as possible and by written report no later than three business days.
14. The written report shall include:
 - a. The names and job titles of the staff who administered the emergency physical restraint, and observers, if any; the date, time and duration, citing onset and end times; and the name of the administrator who was verbally informed following the intervention.
 - b. A description of activities the individual, others, and staff, in the same room or vicinity, were engaged in immediately preceding the use of emergency physical restraint; the behavior that prompted the emergency physical restraint; the efforts made to de-escalate the situation; alternatives to emergency physical restraint that were attempted; and the justification for initiating the emergency physical restraint.
 - c. A description of the administration of the emergency physical restraint including:
 - 1.) The intervention used and reasons the intervention was necessary,
 - 2.) The individual's behavior and reactions during the emergency physical restraint,

- 3.) How the episode ended,
 - 4.) Documentation of injury to the individual and/or staff, if any,
 - 5.) Any medical care provided during or following the emergency physical restraint.
- d. A description of the methods used to monitor the restrained individual's health status, including any specific limitations and risks identified during the BCIP and Health Care Plan development. This includes skin color, respiration, or other indicators of physical distress. Other monitored indications of physical distress shall include choking, vomiting, bleeding, fainting, loss of consciousness, swelling secondary to restraint points, verbal and nonverbal indications of acute pain.
 - e. For extended emergency physical restraint, the written report shall describe the alternatives to extended emergency physical restraint that were attempted, the outcome of those efforts and the justification for administering the extended emergency physical restraint.
 - f. Information regarding any further action(s) that the agency has taken or may take, including any disciplinary sanctions that may be imposed or changes to the individual's Positive Behavior Supports Plan or Behavioral Crisis Intervention Plan.
 - g. Information regarding opportunities for the individual's guardian to discuss the administration of the emergency physical restraint with program staff.
15. The agency whose staff members administer an emergency physical restraint resulting in:
- a. An injury or other reportable critical incident to the individual, and/or;
 - b. An extended emergency physical restraint, and/or;
 - c. Injury to intervening staff,
- shall provide a verbal notice to the Department of Health, Developmental Disabilities Supports Division Office of Behavioral Services, within 24 hours of the administration of the emergency physical restraint, followed by a written report within 48 hours (or the next business day). The written report shall include:
- a. A copy of the agency generated report described above in D. 14. a.-g.
 - b. A record of all emergency physical restraints employed with the identified individual for the 60 calendar days prior to the date of the reported emergency physical restraint.
16. Any agency administering an emergency physical restraint with an individual more than four times in any four week period will report to the Department of Health DDSD/OBS within two business days of the fifth emergency physical restraint event.
17. Any agency administering an extended emergency physical restraint with an individual will report to the Department of Health within two business days.
18. All agencies supporting individuals with whom an emergency physical restraint is employed will convene an Incident Management Team to collect and analyze data drawn from reporting required on a monthly basis. The analysis will be performed with respect to individuals physically restrained, staff employing emergency physical restraint, and agency trends. The report will be centrally maintained and made available to the DDSD/OBS if requested.

E. Provider Agency direct support staff

1. Participates in and successfully completes all pre-service training required by DDS.
2. Participates in and successfully completes the agency approved protocol for crisis prevention and intervention if they will be assigned to support individuals who by recent history exhibit behavior that may necessitate a physical intervention and/or emergency physical restraint to maximize safety.
3. Participates in training on each individual's Positive Support and Behavioral Crisis Intervention Plans as provided by the Support Consultant or his/her designee.
4. Implement emergency physical restraint in accordance with an individual's BCIP when all efforts to de-escalate the crisis have failed to reduce the risk of imminent, serious physical harm.
5. Implement emergency physical restraint only using strategies included in the agency's approved crisis intervention protocol.
6. Implement emergency physical restraint using only the amount of force necessary to protect the individual or others from physical injury or harm.
7. Implement emergency physical restraint using the safest method available and appropriate to the situation as described in the BCIP.
8. Implement emergency physical restraint considering the following safety requirements:
 - a. No emergency physical restraint shall be administered in such a way that the individual is prevented from breathing or speaking. The health status of the individual must be continuously monitored during the administration of an emergency physical restraint with attention to the specific limitations and risks identified during the BCIP development. This includes changes in skin color, respiration, or other indicators of physical distress. Other monitored indications of physical distress shall include choking, vomiting, bleeding, fainting, loss of consciousness, swelling secondary to restraint points, verbal and nonverbal indications of acute pain.
 - b. Emergency physical restraint shall be administered in such a way so as to prevent or minimize physical and psychological harm. If, at any time during an emergency physical restraint, the individual demonstrates significant physical distress through the above indicators, the individual shall be immediately released and staff shall immediately seek medical assistance.
 - c. An emergency physical restraint shall be released immediately upon a determination by the intervening staff that the individual is no longer at risk of causing imminent physical harm to him or herself or others. If, due to unusual circumstances, an emergency physical restraint continues for more than ten minutes, it shall be considered an "extended restraint" for purposes of the reporting requirements.
9. Employ immediate physical intervention, possibly including emergency physical restraint, only as long as necessary to seek other assistance and/or substantially reduce the risk of serious harm if a supported individual presents extreme unique, unprecedented, and unpredicted behavior.

10. Verbally informs their administration as soon as possible and by written report no later than the next business day whenever an emergency physical restraint is administered. The written report shall be provided to the director of the agency or his/her designee.

F. Case Manager

1. Participates in and successfully completes all pre-service and on-going training for case managers required by DDS.
2. Participates in and successfully completes all individual specific training regarding behavior support for his/her active caseload.
3. Convenes an emergency IDT meeting in the event of a rare occasion when an individual presents extreme unique, unprecedented, and unpredicted behavior that requires immediate physical intervention; possibly including emergency physical restraint, that is neither included in a BCIP nor had prior HRC review or approval. The emergency IDT meeting will be convened within two business days to examine the factors contributing to the crisis, explore alternative interventions that may have been used, assess whether the contributing factors persist, and attempt to predict if the presenting behavior is likely to recur. The emergency IDT may be attended by phone due to the short timeline.
4. Maintains and distributes minutes of emergency IDT meetings.

G. Human Rights Committee

1. Participates in available training and technical assistance regarding required constitution and oversight activities for HRC's.
2. Reviews any BCIP that includes the use of emergency physical restraint and/or other rights restrictions. The HRC review shall occur at least semi-annually and whenever any change to the BCIP is considered. The BCIP may not be implemented without HRC review and approval whenever emergency physical restraint or other restrictive measure is included.
3. Maintains HRC minutes of meetings considering and approving or disallowing the use of emergency physical restraint as written in a BCIP.
4. Maintains HRC minutes of meetings reviewing the implementation of the BCIP when emergency physical restraint is used.

For answers to any questions, please contact the DDS Director's office.