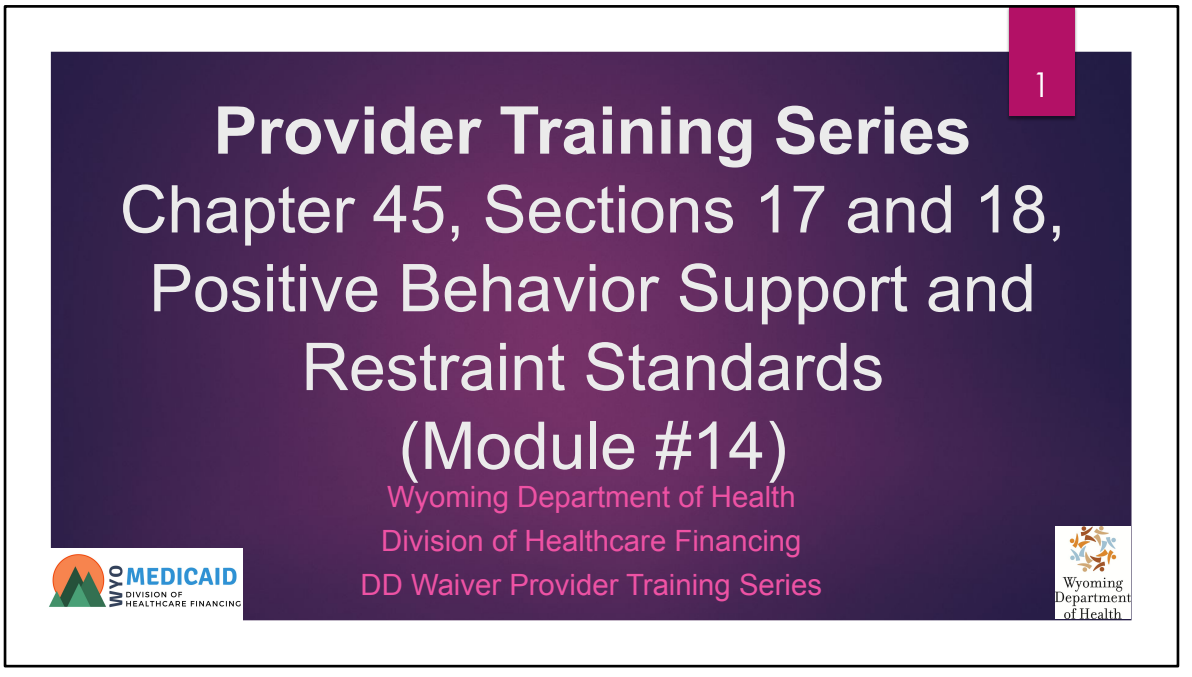


Welcome to the Division of Healthcare Financing (Division), Home and Community-Based Services Section's Provider Training Series for Chapter 45 of the Department of Health's Medicaid Rules (Rules). These rules govern the home and community-based Comprehensive and Supports Waivers, collectively referred to as the DD Waivers.

Chapter 45, Section 15(d) requires waiver providers to complete training in specific areas prior to delivering services. Individuals who complete all of the Series training modules and associated training summaries will be in compliance with this specific requirement. Please note that providers are responsible for ensuring they meet **all** training requirements, which are established throughout Chapter 45, prior to delivering waiver services.

This module covers Sections 17 and 18, which address positive behavior supports and standards for restraint usage.

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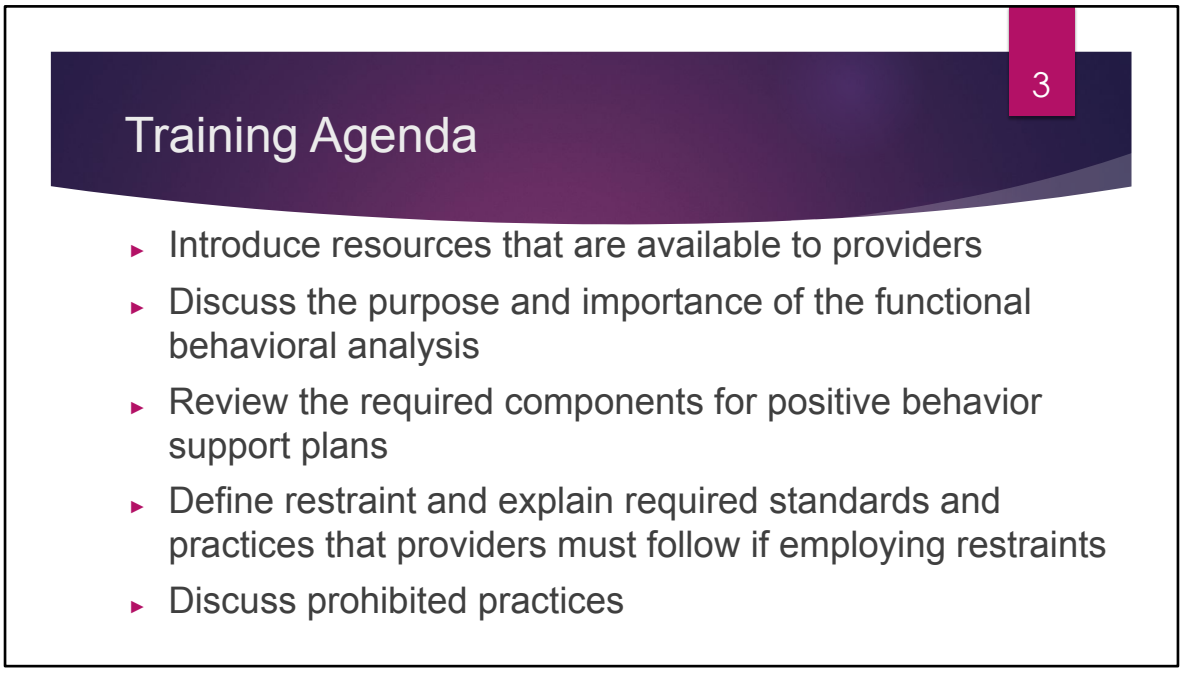
# Purpose of This Training

Set the expectation for positive behavior support, establish requirements for positive behavior support plans, and define restraints and their usage.

The purpose of this training is to set the expectation for positive behavior support, establish requirements for positive behavior support plans, and define restraints and what and how they can be performed.




By the end of this module, the following topics will have been introduced and explained.

- We will introduce the resources offered by the Division that are intended to support providers and plan of care teams members to understand positive behavior support, conduct a functional behavioral analysis, and develop a positive behavior support plan.
- We will discuss the purpose of the functional behavioral analysis, why it is important, and the components that are required.
- We will review the components of the positive behavior support plan that are established in Chapter 45, Section 17.
- We will define chemical, mechanical, and physical restraint, and review required standards and practices that providers must follow if they intend to employ restraints during the course of providing services.
- Finally, we will discuss restraint practices that are prohibited by state and federal law.


A theme throughout all of the Division's provider training modules is the fact that home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives.

Plan of care teams must use a person-centered approach when developing a participant's individualized plan of care (IPC), and any of the components of the IPC, including positive behavior support plans. Participants should be involved in the discussion, and should be aware of and have choice in the strategies that are developed to support them when their behavior escalates. Participants and legally authorized representatives must demonstrate informed consent by signing the positive behavior support plan before it is implemented. If positive behavior support is going to be effective, the participant should buy in to the strategies that are going to be used to support them.

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## What is Positive Behavior Support?

- **Positive** - the plan or intervention must add to the participant's quality of life.
- **Behavior** - The plan or intervention must teach participants new ways to communicate what they want that do not cause harm to themselves or others.
- **Support** - The plan or intervention must support the participant, not punish them.

The purpose of this training is address the rules that apply to positive behavior support plans and restraint standards. We are not diving into the particulars of positive behavior support; however, any provider or staff member working with participants of DD Waiver services should have a general understanding of positive behavior support and implement positive behavior supports with each participant they serve.

So, what is positive behavior support? The main tenet of positive behavior support is that there is a reason behind behavior, and people who demonstrate challenging behavior have the right to be treated with compassion and respect.

Positive behavior support is just that...positive. Positive behavior support focuses on a plan or intervention that adds to the participant's quality of life. It is a strategy that teaches participants how to get what they want, or what they want to get away from, in a way that does not harm themselves or others. The plan or intervention must support the participant in a positive way, rather than punishing or penalizing them.

The Division often sees positive behavior support plans that impose consequences when a participant demonstrates challenging behavior. Plans or interventions that apply consequences that negatively impact the participant are not positive behavior support.

# Available Resources

- **Positive Behavior Support Plan Manual -** Developing and Implementing a Positive Behavior Support Plan
  - HCBS Document Library - DD Tools tab
- **Functional Behavioral Analysis (FBA)/Positive Behavior Support Plan (PBSP) Form**
  - HCBS Document Library - DD Forms tab

Throughout this training we will refer to two important resources that are available to providers. The *Positive Behavior Support Plan Manual* and *Functional Behavioral Analysis and Positive Behavior Support Plan form* are available on the HCBS Document Library page of the Division website. The Manual is available on the DD Tools tab; the FBA/PBSP form is available on the DD Forms tab. The Division strongly recommends that providers become familiar with these documents. The Manual provides extensive information on positive behavior support, as well as details, steps, and strategies for developing a positive behavior support plan.

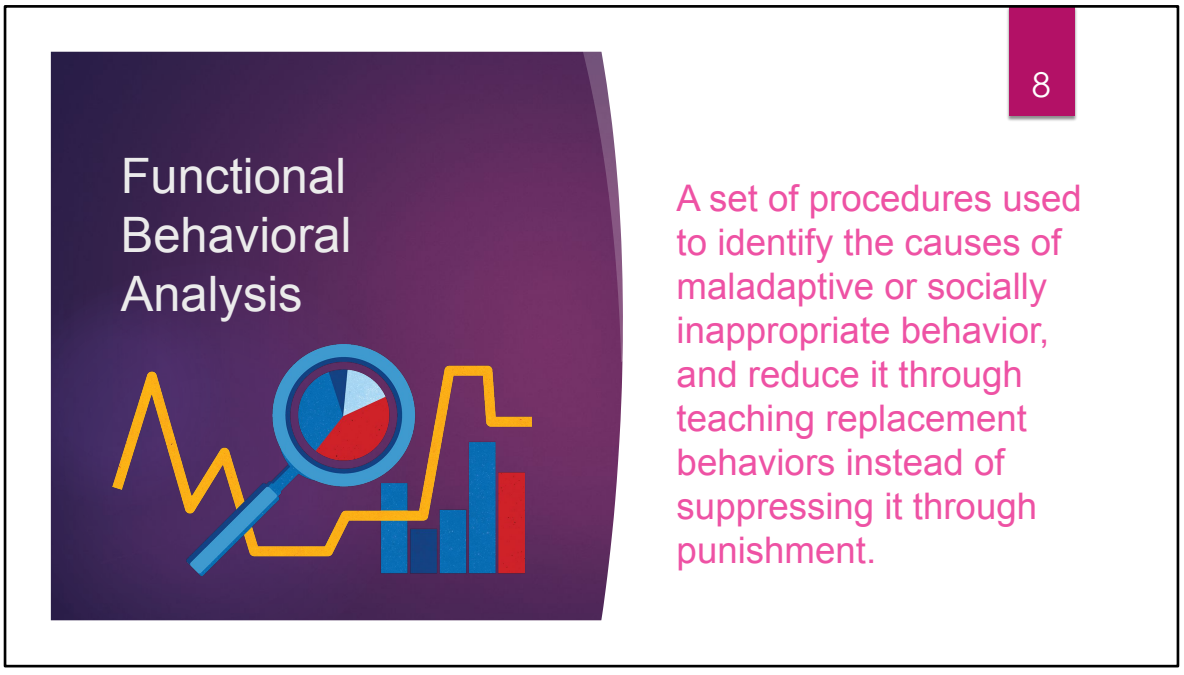
## Challenging Behaviors

- Threaten the immediate health and safety of the participant or others in the environment.
- Persistent pattern that inhibits the participant's functioning in public places and integration within the community.
- Uncontrolled symptoms of a physical or mental condition.

The term *challenging behavior* is meant to address behavior that can negatively impact the participant's ability to participate in their own life. It **does not** refer to behaviors that challenge providers.

Challenging behaviors include:

- Behaviors that threaten the immediate health and safety of the participant or other individuals in the environment;
- Behaviors that result in a persistent pattern that inhibits the participant's ability to function in public places and adversely affects their integration within the community; and
- Uncontrolled behavioral symptoms that are the result of a physical or mental condition.




Before the team can develop or implement any sort of positive behavior support plan, they must first be able to understand the function of the participant's behavior, or what the participant hopes to accomplish by using the behavior.

The functional behavioral analysis, or FBA, is a set of procedures used to identify the causes of challenging or socially inappropriate behavior. The purpose of the FBA is to identify the function or possible purpose of the behavior, explore antecedents and factors that contribute to the behavior, and review and describe potential positive supports and interventions that can be included in a positive behavior support plan. Section 17 requires plan of care teams to ensure that the FBA has been conducted within the last year.

In accordance with Section 17, a provider or provider staff member who knows the participant shall complete the FBA, but the team, participant, and legally authorized representative shall also provide input.

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## Components of the FBA

- A clear description of the behavior;
- Antecedents and contributing factors;
- Motivation;
- Intervention history;
- Baseline data; and
- Ongoing data collection, once positive behavior supports have been implemented.

Section 17 states that the FBA shall include data regarding challenging behaviors that the participant exhibits. The Division offers a simple form to document the required components of the FBA, which we initially introduced in Slide #6.

- A clear description of the challenging behavior, including what the behavior looks or sounds like, if it occurs in conjunction with other behaviors, how long it lasts, and how long the participant has been demonstrating this behavior.
- A description of the antecedents or other factors that contribute to the behavior, including any warning from the participant before the behavior starts, if there are specific settings in which the behavior occurs, and medical or physical factors that contribute to the behavior.
- The participant's motivation for displaying the behavior, including what they may be trying to communicate, or what they may want to get or get away from.
- A history of the interventions that have been tried in the past, and what has or has not worked.
- A summary of the frequency, intensity, and duration of the challenging behaviors prior to implementing positive behavior support.
- After implementing positive behavior support, a summary of at least six months of data collection that demonstrates whether or not the positive behavior support was effective. A summary of internal and reportable incident reports should be part of this data collection.

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## Data Driven Responses

- Time of day
- Location
- Activities that are occurring
- People present


Observation is the foundation of the FBA. In its simplest form, an observation is used to understand and describe what the participant's behavior looks like.

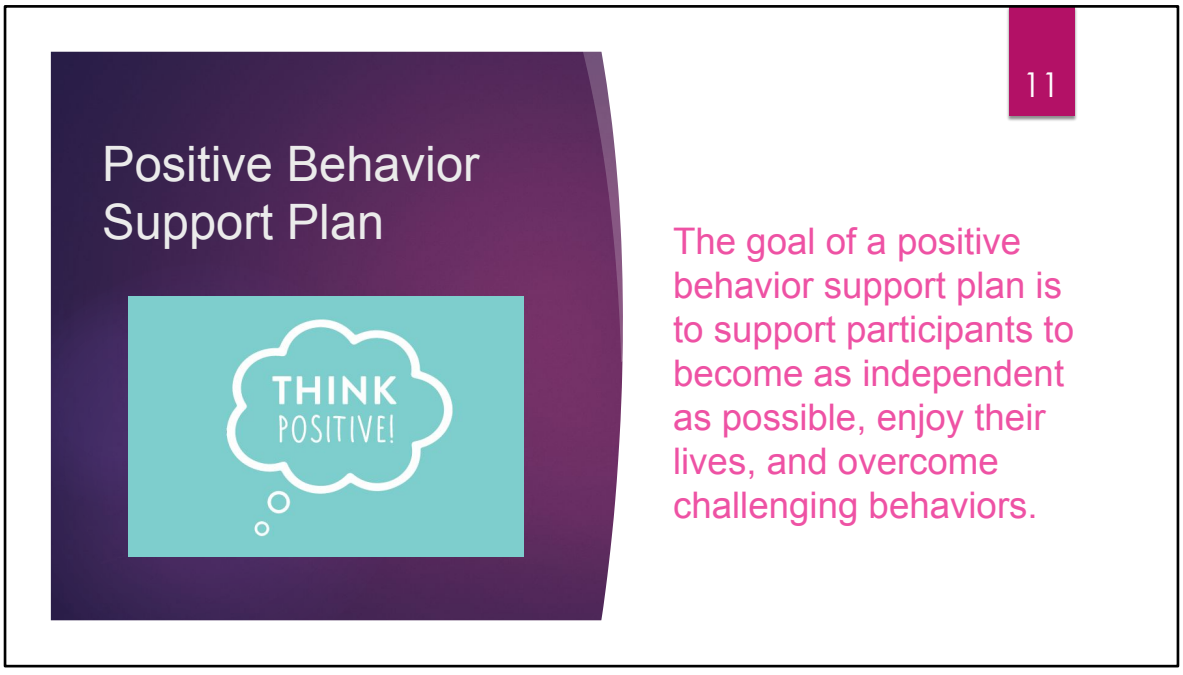
Anecdotal behavioral observations are informal in nature and may be based on recollection of the participant's behavior earlier in the day, notes about a participant's behavior, or scatter plots involving time periods when the behaviors occurred. In contrast, systematic behavioral observations are more structured and controlled. The observer is trained and watches the participant while recording their observations. In some instances, the observer may review a video of the participant; however, video monitoring in a participant's bedroom or bathroom is strictly prohibited.

Regardless of which observational technique is used, it is important to conduct as many observations as possible so that there is confidence that the data obtained is accurate and reflective of the participant's typical behavior. During the observation, the observer should note the antecedents, which are the conditions that immediately precede the occurrence of the participant's behavior. These can include the specific time of day, settings, people, and activities that are present or occur before the behavior. The observer should also clearly and completely describe the participant's behavior, including what they are doing, how often the behavior occurs, the length of the occurrence, and the intensity. Finally, the observer should document the events that immediately follow the behavior, including how the provider responds to the participant, as well as the activities and objects that the participant either escapes or has access

to as a result of the behavior.

This information can be used to form a hypothesis of why the participant is displaying the behavior, and how to positively support the participant in replacing the behavior with a safer and more socially acceptable alternate.

For more information on how to conduct a functional behavioral analysis, please refer to the PBSP Manual, which was initially introduced on Slide #6.




In accordance with Section 17, a positive behavior support plan, or PBSP, that is based upon a current functional behavioral analysis shall be developed for a participant in order for providers working with the participant to understand and recognize the communication and behaviors exhibited by the participant. The PBSP shall describe agreed upon supports and non-restrictive interventions that providers will need to employ in order to assist the participant.

Although it is not necessary for every participant to have a PBSP, one must be developed if a participant has restraint written into their IPC. It is also best practice for participants who have targeted behaviors rated as moderate or high identified on an Inventory for Client and Agency Planning (ICAP) assessment, or for those who have had an increase in incidents related to their behavior, to have a PBSP as part of their IPC.

Although the PBSP is developed to support the participant, it should be written for the provider and describe how they should respond and interact with the participant in order to support them and teach them alternative behaviors. The PBSP should include long and short-term strategies that are developed based on the FBA, knowledge of the participant's lifestyle, and the vision the participant has of their life. It should describe the rationale for plan of care team decisions, be designed to fit the participant's daily life, and take into consideration natural routines and structure of the participant's environment, such as day time activities, employment, and home life.

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## PBSP Components - At a Minimum

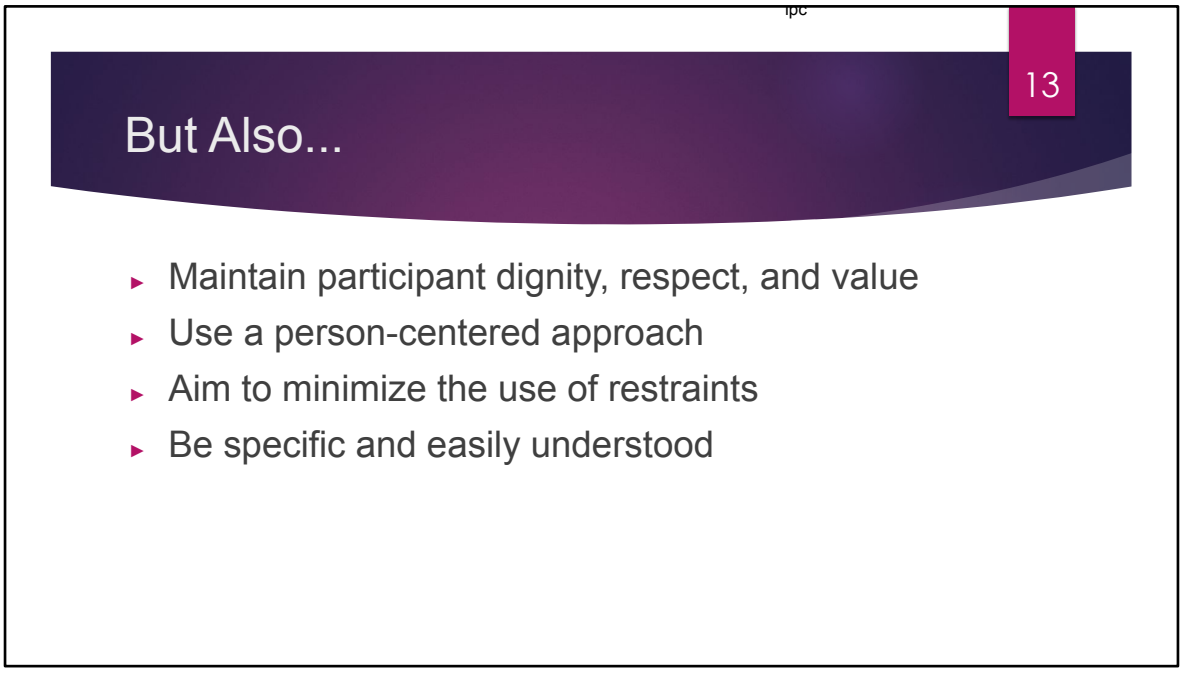
- Include the components of the Division's template:
  - Targeted behaviors that need to be reduced or replaced, and how the team will recognize emerging behaviors
  - A list of positive supports, and what the team will be expected to do when implementing the intervention strategies
  - Replacement behaviors and reinforcers
  - Escalation and PRN medications (if applicable)
  - Review protocol
  - Documentation and signatures

Section 17 establishes the components that must be included in a PBSP. Plan of care teams are not required to use the template provided by the Division, but the PBSP must include all of the components that are are addressed in the Division's template.

The PBSP must:

- Describe the antecedents and challenging behaviors that need to be replaced or reduced, and the positive supports that are needed to help the participant replace the challenging behaviors with appropriate behaviors.
- Describe how the plan of care team, provider, and provider staff members will recognize emerging behaviors.
- Describe what the plan of care team, provider, and provider staff members will be expected to do when implementing the intervention strategies, including specific instructions for the provider as to how they will intervene when the behavior occurs.
- Include a list of replacement behaviors, which are the behaviors that are more desired and address the motivation of the participant.
- Include a list of reinforcers, which include the responses that providers and provider staff members will display when the participant changes their behavior.
- Include a protocol for PRN medications, if applicable, that describes how providers and provider staff members will determine that the escalation of the behavior requires a behavioral PRN as recommended by the treating medical professional.
- Include a protocol that identifies who will review the PBSP's effectiveness, how often

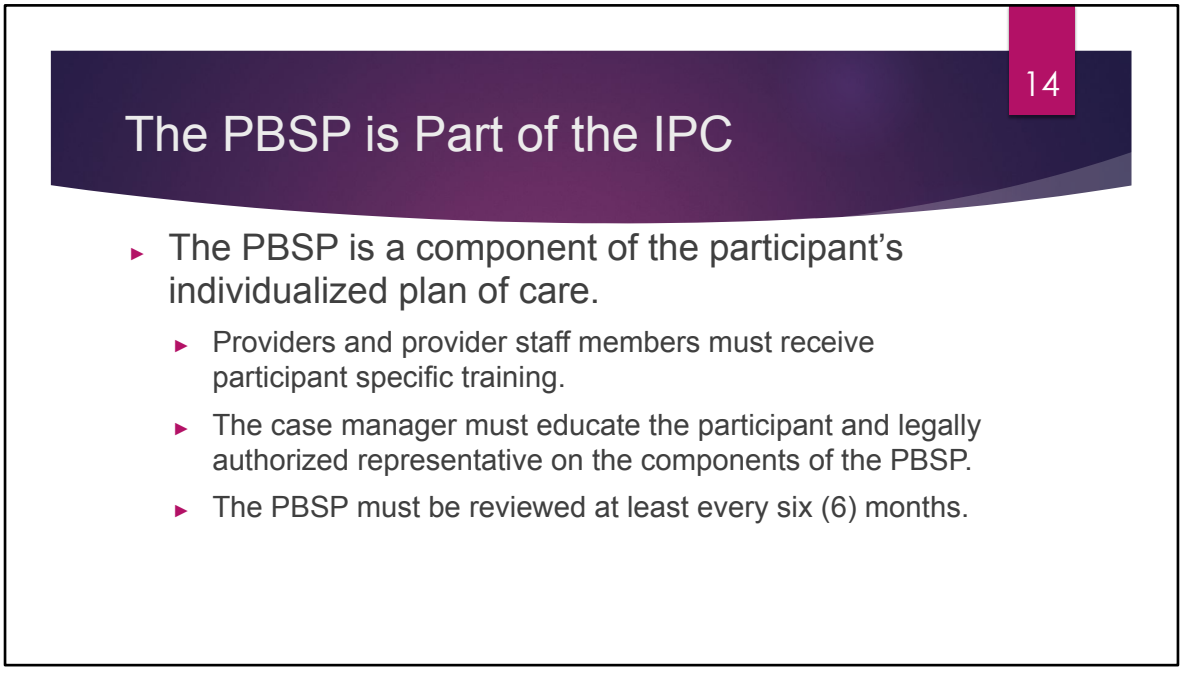
- the PBSP will be reviewed, and who will revise the PBSP when necessary. In accordance with Section 17, the PBSP must be reviewed at least every six months; however, it can and should be reviewed more often if it isn't effective or there have been changes in the participant's life.
- Include a summary of the dates and times that the targeted behavior occurs, a description of the antecedents to the behavior, and the positive behavioral interventions used. Additional information such as the frequency, intensity, and duration of the behaviors is highly recommended.
- Finally, the PBSP must include signatures of the participant or legally authorized representative, which verifies that the participant provided informed consent to implement the PBSP.




In addition to the required components of the PBSP, the plan of care team must ensure that other standards are met when developing and implementing a participant's PBSP.

- The plan of care team must ensure that, throughout the process, the participant is treated with dignity and respect, and their choices are valued.
- The PBSP must be developed using a person-centered approach, meaning that during development of the PBSP, the team considers the participant's whole life, assists the participant in gaining control over their life, increases opportunities for participation in the community, and recognizes the participants desires, interests, and dreams.
- The plan of care team must aim to minimize the use of restraints. This means that they must ensure that the participant's IPC is not implemented in a way that could actually escalate their behavior, and that the strategies identified in the PBSP are supporting the participant to get or get away from the circumstances that are causing the behavior.
    - For example, Karen is a participant who receives Comprehensive Waiver services. Karen has a history of trauma related to hunger, so having food available is very important to her. Karen has been diagnosed with diabetes, and has a letter from her licensed medical professional that states that she needs to follow a diabetic diet. The plan of care team, in trying to adhere to the medical professional's recommendation and keep Karen safe, has agreed that Karen's IPC should limit Karen's access to food when it isn't meal time. Not having access to food is a trigger for Karen, due to her past trauma. Not having access

    - to food causes Karen to become fearful, and then angry, and she demonstrates this anger by throwing items that are in the kitchen. In this example, the way the IPC is written and being implemented is causing Karen's behavior to escalate. Rather than removing Karen's access to food, they should identify ways for her to have access to her food while also promoting her health.
- The PBSP needs to be very specific, and outline exactly what is expected in a way that is easily understood so that everyone who is implementing the PBSP is responding the same way. Providers and provider staff members must be consistent in how they implement the PBSP, or it could cause confusion and frustration for the participant.




The PBSP is a formal component of the participant's IPC. If a provider is required to implement a PBSP as part of the services they provide, they must have access to the full PBSP. Case managers must ensure that the PBSP is printed and included as part of the IPC they give to the provider. In accordance with Section 15, case managers shall train one employee from each provider on the IPC. This includes training on the PBSP. The provider is then responsible for ensuring that all staff members who will be implementing the PBSP receive training as well.

The case manager is also responsible for educating the participant and legally authorized representative on the various components of the PBSP. The participant or legally authorized representative is required to sign the PBSP, which indicates that they understand and agree to the strategies listed in the PBSP, but they should not sign until they have been educated and understand the content of the PBSP.

All components of the IPC, including the PBSP, must be reviewed at least semi-annually, when the participant's circumstances or needs change significantly, or at the request of any team member.

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## The PBSP and Restraints

- Participants shall have a PBSP in place if restraints are outlined in their IPC.
- If restraints are used, or law enforcement is contacted due to a behavioral emergency, the PBSP has failed and must be reviewed.

As we prepare to dive into restraint standards, it is important to note that if a participant has restraints outlined in their IPC, they must have a PBSP in place.

If a restraint is performed on a participant, or if a law enforcement agency has been contacted to respond to a behavioral emergency, then the PBSP has failed. The plan of care team must review the PBSP and determine if additions or modifications need to be made to the participant's service environment or behavioral interventions.

16

## Restraint Standards


When the use of positive behavior support is not effective, the plan of care team may implement a restraint protocol to supplement the PBSP.

Chapter 45, Section 18 establishes restraint standards for participants of DD Waiver services. In accordance with this Section, when the use of positive behavior supports is not effective in modifying or changing a participant's challenging behavior, the participant's plan of care team may implement a restraint protocol to supplement the PBSP. The restraint protocol must adhere to all of the standards outlined in this Section. Restraint encompasses physical, chemical, and mechanical restraints.

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## Chemical Restraint

***Any drug that is administered to manage a participant's behavior in a way that reduces the safety risk to the participant or others, has the temporary effect of restricting the participant's freedom of movement, and is not a standard treatment for the participant's medical or psychiatric condition.***

A chemical restraint is defined as any drug that is administered to manage a participant's behavior in a way that reduces the risk to the participant or others, has the temporary effect of restricting the participant's freedom of movement, and is not a standard treatment for the participant's medical or psychiatric condition. Additionally, the Division considers any drug, regardless of the route of administration, that has the temporary effect of controlling behaviors, inducing sedation, and is administered against the will of the participant either by force or coercion, to be a chemical restraint.

As established in Section 18:

- A chemical restraint shall not be used unless it has been ordered by a licensed medical professional and administered by a person licensed to administer the medication.
- Standing orders for chemical restraints are prohibited, unless they are necessary to prevent extreme reoccurring behavior. A standing order shall include clarification from the licensed medical professional on the circumstances of its usage, and be limited to one month.
- If a provider performs three (3) or more chemical restraints on a participant within a consecutive six (6) month period, the participant's plan of care team shall arrange for the participant to see their treating medical professional for a formal medical review in case the participant's treatment plan needs to change. The participant's plan of care team shall meet to determine if the PBSP or restraint protocol needs to change. If it is determined that the treatment plan or IPC will not be changed, then the case manager

- must include justification of that decision in the IPC.

Chemical restraints shall not be used on participants under the age of eighteen (18).

18

## Mechanical Restraint

***Any device attached or adjacent to a participant's body that they cannot easily move or remove that restricts freedom of movement or normal access to the body.***

A mechanical restraint is defined as any device attached or adjacent to a participant's body that they cannot easily move or remove that restricts freedom of movement or normal access to the body. Mechanical restraints shall only be used under the direct supervision of a licensed medical professional for the purpose of medical treatment procedures when compliance with the medical treatment is deemed necessary to protect the health of the participant.

Mechanical restraints shall not be used on participants under the age of eighteen.

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## Physical Restraint

***The application of physical force without the use of any device, for the purpose of limiting the free movement of a participant's body.***

A physical restraint is defined as the application of physical force without the use of any device, for the purpose of limiting the free movement of a participant's body. Physical restraint does not include briefly holding a participant, without undue force, in order to calm or comfort them, or holding a participant's hand to safely escort them from one area to another.

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## Restraint Protocol

Including:

- The legal document, court order, guardianship papers, or medical orders that demonstrate authority to authorize restraint
- Demonstration that standards outlined in Section 4 are met.

In rare circumstances, a restriction on a participant's right to be free from restraint can be imposed. Chapter 45, Section 4 establishes that, before this type of rights restriction can be imposed, a court, participant, or participant's legally authorized representative must authorize the restriction in writing. If an individual other than the participant is authorizing the use of restraints, the legal document or medical orders that demonstrate this authority must be on file.

In addition to the written authorization, this type of rights restriction must be accompanied by letters from both a licensed medical professional and a licensed behavioral professional detailing the medical and psychological contraindications that may be associated with the restraint. The Division is not requesting that teams seek permission from licensed professionals. If a restraint is part of a participant's IPC, it is important for the team, and especially the provider that may be performing the restraint, to understand the medical and psychological concerns that are present.

- Concerns such as brittle bones or respiratory challenges may be included in a letter from a medical professional.
- Past trauma or aversion to touch may be outlined in a letter from a behavioral professional.
- If there aren't any concerns, that should be noted in the letter(s) as well.

This information must be included in a restraint protocol that explains the circumstances in

which a PBSP has failed and the use of restraint is required.

Because this is a restriction of a participant's rights, the participant's IPC must meet the standards outlined in Section 4 related to standards that must be met in order to restrict a participant's rights.

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## Provider Training


- De-escalation techniques, crisis prevention and intervention, and and proper restraint usage
  - All providers performing restraints
- Positive behavior support training
  - Providers with more than five (5) participants with restraints listed on IPC

Before a provider or provider staff member can perform restraints, they must complete required trainings. Restraints can only be performed by an individual who has been trained and certified in de-escalation techniques, crisis prevention and intervention, and restraint usage through Mandt, Crisis Prevention Intervention (CPI), or another entity approved by the Division.

If a provider delivers services to five or more participants who have restraint listed in their IPC, at least one staff member must have completed training on positive behavior supports through a program approved by the Division. An additional staff member must be trained for each additional ten participants with restraints listed in their IPC.

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## Provider Policies and Procedures

- Adopt policies and procedures that:
  - Identify the provider's chosen certifying entity;
  - Specify the types of restraints that may be used by provider staff; and
  - Establish provider-specific training requirements for staff.
- Only utilize restraints approved by the provider's chosen certifying entity.
- Adhere to all state and federal statutes, rules, and regulations regarding the use of restraints.

If a provider employs restraints during the delivery of services, they must meet additional standards. They must develop, adopt, and implement a policy that identifies the entity they will use to certify staff members, specify the types of restraints that may be used by provider staff members, and establish training requirements for their staff members, such as how soon retraining will be conducted if an employee injures a participant when applying a restraint. Providers shall only perform restraints that are approved by their certifying entity, and then can only employ those restraints if they meet the standards outlined in Section 18. As an example, the certifying entity may provide training on how to restrain an individual on the floor. Even if the certifying entity allows for this practice, this practice is strictly prohibited in this Chapter.

Providers are required to adhere to state and federal statutes and rules related to restraint usage.

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## Provider Practices

- Maintain documentation;
- Implement supports and techniques to minimize or mitigate behavior;
- Correct and retrain staff members, when necessary;
- Notify the Division, case manager, and legally authorized representative when a restraint occurs; and
- Collect and review available data.

There are other specific practices that providers employing restraints must follow. Providers must:

- Generate and maintain documentation to track and analyze each use of a restraint, including the antecedents, reason for the restraint, the participant's reaction to the restraint, and provider actions that may make future restraints unnecessary;
- Implement additional supports, and use appropriate de-escalation techniques to redirect or mitigate a participant's behavior in order to minimize the need for restraints;
- Correct a staff member if they perform a restraint incorrectly;
- If an injury occurs as a result of a restraint, conduct staff retraining within five (5) business days of the injury being detected;
- Hold a debriefing meeting with the participant, legally authorized representative, and case manager as soon as practicable after an incident involving a restraint occurs;
- Ensure the case manager and legally authorized representative have access to the provider's internal tracking form within five (5) business days of an event involving a restraint;
- Submit an incident report to the Division within one business day each time a restraint is used; and
- Regularly collect and review all available data regarding the use of restraints and implement strategies to reduce their duration and frequency, or eliminate their occurrence altogether.

Details on these practices should be included in the provider's restraint policy.

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## Case Manager Responsibilities

- Follow up on each restraint incident within two business days.
- Report suspected non-compliance to the Division.
- Convene a plan of care meeting if restraints are used in the previous calendar quarter or if an emergency restraint is performed.
- Review restraint data as part of their monthly case management review.

Case managers have specific responsibilities related to restraints.

First and foremost, the case manager must follow up with the participant within two business days of the day the case manager was notified of the incident to ensure that the participant is safe and uninjured. During this follow up, they must speak with the provider to ensure that the PBSP and restraint protocol were implemented correctly, and review documentation to verify that less restrictive intervention techniques were used prior to the restraint being performed. The case manager is obligated to report suspected non-compliance with participant protocols or Division rules to the Division.

The case manager is responsible for convening a plan of care team meeting if a restraint is performed on a participant during the previous calendar quarter. During that meeting, the team must review the restraint incidents and develop a plan to reduce the number of restraints performed.

If an emergency restraint is performed, meaning that the participant subject to the restraint did not have restraint written into their IPC, the case manager must convene the plan of care team within two weeks to discuss the need for a formal restraint protocol.

The case manager is responsible for reviewing incident reporting data and restraint usage as part of their monthly case management tasks. Each quarter, they must report restraint data on

the required quarterly case management report.

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## Emergency vs. Authorized Restraints

- Notify the case manager and legally authorized representative within one business day.
- Submit an incident report, as established in Section 20.
- Convene a plan of care team meeting within two weeks
  - Does the participant need a restraint protocol?
  - Does the PBSP need to be revised?

On rare occasions, a participant who doesn't have restraint listed in their IPC may demonstrate behavior that is immediately dangerous to themself or someone else. If a provider has the training required to perform a restraint, they can do so only to keep people from immediate harm. If a provider does not have the necessary training, they cannot perform a restraint.

If an emergency restraint is performed, the provider must contact the case manager and legally authorized representative within one business day to let them know the restraint occurred. They must submit an incident report for the use of a restraint within one business day of the occurrence. Finally, the case manager must convene the plan of care team within two weeks to discuss the incident and determine the the participant's IPC needs to be modified to include a restraint protocol, or if the PBSP needs to be revised.

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## Restraints Are a Last Resort

***Restraints shall only be used in emergency circumstances to ensure the immediate physical safety of the participant, a provider staff member, or other persons, and when less restrictive positive behavior supports have been determined to be ineffective. Providers shall only use restraints when the risk of injury without restraint is greater than the risk associated with the restraint.***

A restraint should be used as a last resort, and only applied if other less restrictive interventions have been tried and failed. Less restrictive interventions must be written into the restraint protocol so all team members are aware of strategies that can be used to de-escalate situations and perhaps avoid the need for a restraint. These less restrictive interventions are also included in the positive behavior support plan.

As established in Section 18, restraints shall only be used in emergency circumstances to ensure the immediate physical safety of the participant, a provider staff member, or other people, and when less restrictive positive behavior supports have been determined to be ineffective. Providers shall only use restraints when the risk of injury without restraint is greater than the risk associated with the restraint.

Restraints shall be time-limited and removed immediately once the participant no longer presents a risk of immediate harm to self or others. For example, Billy is throwing large objects at Sue. Sue uses a walker for mobility, and is unable to leave the area quickly enough to avoid being injured, so the provider determines that Billy needs to be restrained so that Sue can leave the room. Once Sue leaves the room, the provider needs to end the restraint. Even if Billy starts throwing objects again, there is no one in the room that can be harmed, so the restraint is no longer necessary or appropriate.

But what if Billy is throwing objects, or punching walls, but isn't in jeopardy of hurting Sue or

himself? Is this a reason to restrain Billy? The answer is no. You should never restrain someone simply to avoid property destruction. This is not an emergency circumstance. Restraints are for the sole purpose of protecting a person, not for protecting property. Any time a restraint is imposed there is a risk of serious injury, either to the person performing the restraint or to the person who is being restrained. Property can be replaced...people cannot.

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## Prohibited Practices

Providers shall not use aversive techniques to modify a participant's behavior.

Providers shall not use aversive techniques to modify a participant's behavior. Aversive techniques include any intervention that causes pain, harm, discomfort, or social humiliation for the purpose of modifying or reducing a behavior.

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## Prohibited Restraints

- Contraindicated by the participant's medical or psychological condition
- A procedure or device that obstructs a participant's airway or constricts the participant's ability to breathe
- A supine or prone restraint
- Other restraints not provided for in Rule

The following restraints are prohibited:

- A restraint that is contraindicated by the participant's medical or psychological condition. This information will come directly from the letters from the licensed medical and behavioral professionals that detail these contraindications and are required pursuant to Section 4.
- A restraint procedure or device that obstructs a participant's airway or constricts the participant's ability to breathe.
- A supine or prone restraint, meaning a restraint that is applied while a participant is lying face down or on their back including, but not limited to, restraining a participant on the floor, in a bed, in any form of reclined chair, or using any other horizontal flat surface.
- Any physical, mechanical, or chemical restraint that falls outside of the standards established in Section 18.

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## Prohibited Purposes for Restraints

- For the convenience of the provider
- To coerce, discipline, force compliance, or retaliate
- As a substitute for habilitation program

As we mentioned earlier, when a restraint is performed on a participant, the staff member employing the restraint is restricting a participant's right to be free from restraint. Remember, any time a restraint is imposed, there is the potential for someone, either the participant or the staff member, to be injured. Restraints are a big deal, and should not be taken lightly. Restraints should never be used for the convenience of the provider; to coerce, discipline, force compliance, or retaliate against a participant; or as a substitute for a habilitation program or in quantities that interfere with a participant's services, treatment, or habilitation

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## A Word About Seclusion


Seclusion is prohibited, and may result in adverse actions.

Seclusion is the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving. Seclusion is prohibited, and may result in adverse actions imposed on any provider who employs seclusion during the course of supporting a participant.

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## Adverse Actions Apply

Any violation of the standards listed in the prohibited restraints or purposes of restraints may result in immediate adverse action of the provider.


If a provider or provider staff member violates any standard in this Section, the provider will be subject to immediate adverse actions.


As we end this training, we'd like to review some of the key takeaways:

1. The main tenet of positive behavior support is that there is a reason behind behavior, and people who demonstrate challenging behavior have the right to be treated with compassion and respect. Positive behavior support teaches participants how to get what they want, or what they want to get away from, in a way that does not harm themselves or others. The plan or intervention must support the participant in a positive way, rather than punishing or penalizing them.
2. Plan of care teams must use a person-centered approach when developing a PBSP. The PBSP must include all of the components outlined in Chapter 45, Section 17.
3. The PBSP is written for the provider. It is the provider's roadmap, and should guide them through how they should respond and interact with the participant in order to support them and teach them alternative behaviors.
4. Restraints are a rights restriction. They should be used as a last resort, and only applied if other less restrictive interventions has been tried and failed. Less restrictive interventions must be written into the PBSP so all team members are aware of strategies that can be used to de-escalate situations and perhaps avoid the need for a restraint.
5. Restraints are a big deal and should never be taken lightly. Any time a restraint is performed, there is the potential for someone, either the participant or the staff member, to be injured. Restraints should never be used for the convenience of the provider or to coerce, discipline, force compliance, or retaliate against a participant.


Thank you for participating in today's training. If you have questions related to the information in this training, please contact your Division representative. Contact information can be found by clicking on the link provided in the slide.

**Don't read this section as part of the live presentation**
*Please be sure to complete a summary of this training so that you can demonstrate that you received training on the rights of participants receiving services.*