West Bay Rhode Island, Inc.

POLICY FOR BEHAVIOR SUPPORT THAT UTILIZES INDIVIDUALIZED POSITIVE BEHAVIOR THEORY AND PRACTICE AND PROHIBITS ABUSIVE PRACTICES

UPDATED 1/21

INTRODUCTION

Due to many factors, including social ecology and physiological predisposition, individuals with disabilities are often vulnerable to the development of challenging behaviors. Challenging behaviors are those behaviors that an individual has developed which interfere with the quality of his or her life, and may prevent full inclusion into the community. Such behaviors, including but not limited to aggression, self-injury, and other types of disruptive behaviors, often arise from frustrated attempts by the individual to meet personal needs for attention, control, communication, social interaction, etc. Challenging behaviors may also arise from medical problems, psychiatric dysfunction, or environmental stressors. West Bay Rhode Island, Inc. (West Bay) recognizes the complex nature of these types of challenging behaviors and is committed to providing effective behavioral treatment in the most holistic, person-centered context possible. We firmly believe that the goal of any behavioral treatment plan which encompasses the use of behavior analysis, behavior modification, or other purposeful attempt to clinically manipulate behavior, is solely to increase the quality of an individual's life. We believe that a behavior treatment plan is

Warranted only when the behaviors displayed by the individual prevent him or her from achieving the best life possible or when those behaviors place the individual or those around him at risk of harm or serious disruption. We emphasize the use of positive approaches, prohibit abusive approaches, and turn to least aversive alternatives only as a last resort, only with extensive safeguards and monitoring, and only when the benefits of such an approach outweigh possible risks. We further believe that any behavioral treatment plan must address the underlying causes of the challenging behaviors and must not provide only immediate symptom control. These fundamental beliefs drive the development of all behavioral interventions at West Bay.

STATEMENT OF STATUTORY AND REGULATORY COMPLIANCE

A. Behavioral Supports are interventions to develop and strengthen adaptive and appropriate behaviors through the application of behavioral interventions, and to simultaneously reduce the frequency of inappropriate behaviors. Behavioral Supports and interventions encompass behavioral analysis and other similar interventions that refer to purposeful, clinical support of behavior.

1. All behavioral supports and treatment shall conform to and abide by R.I. Gen. Laws Chapter 40.1-26 entitled “Rights for Persons with Developmental Disabilities.”

2. Participants shall give written informed consent prior to the imposition of any plan designed to modify behavior including, but not limited to, those plans which utilize restrictive interventions or impairs the participant’s liberty.

a. A guardian, family member or advocate can provide written informed consent if the participant is not competent to do so.

b. If a participant is competent to provide informed consent, but cannot provide written consent, the agency shall accept an alternate form of consent, such as verbal agreement obtained and witnessed, and document in the participant’s record how such consent was obtained.

B. Behavioral Supports shall be developed and implemented in accordance with Positive Behavioral Intervention and Supports as an evidence-based approach to individual behavior and behavior interventions.

PROACTIVE POLICIES AND PROCEDURES

Referral and Assessment

Initial Referral

People with disabilities often exhibit behaviors that appear different from behaviors of people without disabilities. Such differences do not necessarily suggest a need for intervention to modify the behavior. Individuals who are referred for potential behavioral intervention are assessed with regard to the degree to which the behaviors of concern are disruptive, distressing, or dangerous to both that individual and the people around him or her. This assessment is done by qualified personnel through interviews with the individual, observations of the individual, interviews with significant others/support persons, etc., record reviews, and data collection to determine patterns of occurrence of the behaviors of concern. Individuals whose behaviors are determined to be unique, non-threatening styles of interaction and whose lives are not disrupted by the presence of these behaviors are not deemed candidates for further behavioral intervention.

Further Assessment: Environmental and Medical Factors

Individuals who are identified as exhibiting challenging behaviors which do cause disruption or distress to the individual are further assessed. The basic assessments at this level include a thorough simultaneous review of environmental conditions as well as possible medical factors which may be contributing to the pattern of behavior. Simple to change factors such as physical environment, styles of interaction by support persons, or scheduling difficulties are reviewed. It is often possible to modify the environment and provide conditions which best support optimal behavior and eliminate the challenging behaviors quickly. Likewise, medical factors such as illness, physical discomfort, or medication side effects may be identified and treated with the end result of reduced challenging behavior.

If such assessments and follow up interventions do not yield helpful results, a more in depth functional assessment is warranted.

Functional Assessment

A functional assessment is an approach to understanding challenging behavior in terms of the function or purpose that the behavior serves for the individual. Behavioral theory strongly suggests that behavior does not occur without a cause and that causes for behavior are identifiable. The functional assessment helps to .identify causes of challenging behaviors in terms of their usefulness to the individual in serving needs for communication, personal

control, tangible gains, social interaction, and self-regulation. Once the function (or more likely, functions) of behavior are identified, alternate means for helping the individual fill those needs through positive, pro-social behaviors are explored and implemented . The functional assessment is achieved through data collection and thorough record review, in depth interview and observation, identification of environmental, social, and medical factors contributing to the problem, identification
of target behaviors for change, and identification of positive replacement behaviors which will be taught and reinforced through the behavioral intervention plan. ***(Attachment C: FBA INTERVIEW FORM)***

Psychiatric Assessment

As the assessments described above are being completed, it sometimes becomes clear that the cause for the observed challenging behavior is internal to the individual and is not accounted for by obvious environmental or medical factors. In such cases, referral is made for psychiatric assessment. It is understood that psychiatric assessment can occur along with the other assessments described and that evidence of psychiatric dysfunction does not preclude behavioral treatment in addition to psychiatric intervention. Indeed, behavioral and psychiatric approaches are likely to work best when used in concert with each other. ***(Attachment D: Pre Psychiatric Consult Form)***

BEHAVIORAL INTERVENTION

West Bay recognizes that different types of behaviors that interfere with function or quality of life require different levels of analysis, intervention, and documentation. West Bay has designated the following classification system for determining the minimal standards and requirements for different types of intervention:

LEVEL l **Informal Consultation**
Clinician provides advice or consultation specific to a short- term problem or reaction being experienced by an individual ***Examples:*** How can we help Joe deal with his mother's death? When should we tell Tom the manager is leaving? May be oral-no written plan May be informal note written in house log to guide staff in interactions May be informal follow up/review
LEVEL II **Guidelines for Interaction**
Written suggestions to address longer -standing situations that only mildly interfere with the function of the individual ***Examples:*** If AI tries to hug you, you should... If John becomes over focused on his health, you should... ***Requires:*** Written guidelines Ongoing review of progress that may be included in annual ISP report
LEVEL III **Indirect Therapy**

Behavioral Support Plan Non-Restrictive
Therapy that involves provision of a formal plan for alteration of environmental conditions to enhance behavioral function when there are seriously interfering behavioral difficulties ***Examples:*** Mary's plan to earn check's for demonstration of anger management skills Maxine's self-monitoring checklist for daily chores ***Requires:*** Written plan for positive behavioral support Measurable goals/objectives. Data collection/observation. Reporting of progress **1** to 4 times/year.

LEVEL IV Direct Therapy Plan of Care
Therapy that involves meeting with individual on a regular basis OR that involves use of psychiatric medications. *Examples:* Counseling Psychiatric Treatment Participation in therapy group *Requires:* Written treatment plan or Plan of Care Measurable goals and objectives. Reporting of progress by 1-4 times a year
LEVELV Indirect Therapy Behavioral Support Plan Aversive or restrictive procedure

A written plan that includes contingencies deemed restrictive by state and West Bay standards.
Used to address extremely serious behavioral difficulties only after positive support approaches have failed or been ruled out.
Examples: Any plan including, restraint, response cost, exclusionary time out etc.
**Plan Includes:

- All written components of functional assessment
- Definition of target behaviors
- Rationale for use of procedure
- Safeguards to protect client Measurable goals/objectives Data collection procedures

Requires:

- Reports 1-4 times/year
- Review by HRC at minimum once a year Review by PRC 1-4 times/year
- Yearly approval by individual or legal guardian Yearly approval by licensed physician

POSITIVE CLINICAL STRATEGIES

Following consultation and initial data collection, the Behavior Support Plan is developed. The ISP team participates in the program development and the program is tailored to the needs and interaction styles of the individual receiving services. All staff are trained and monitored in the implementation of positive clinical strategies. ***(Positive Behavioral Support Training)***

The basic outline for the Behavior Support Plan at West Bay is:

BEHAVIOR SUPPORT PLAN FORMAT
1. Introduction
a. history
b. description
c. current status
2. Specified named staff to implement and monitor the plan
3. Target behaviors and Definitions
4. Functional Assessment Summary
5. Current Levels and Goals
5. Positive Support Strategies
6. Specific instructions for staff to implement the strategies of the plan
7. Early warning signals or predictors that may indicate a potential behavioral episode and a clearly defined plan of response and de-escalation
6. Program Materials
7. **Restrictive Procedures*
*8. *Rationale For Use Of Restrictives*
*9. *Risks and Safeguards*
*10. *Review and Exit Criteria*
11. Interactional Style and Guidelines
12. Guidelines for Specific Situations
13. Procedure for evaluating the effectiveness of the plan: collecting and reviewing data on frequency, duration and intensity of the behavior.
15. Sufficient, qualified, trained staff to implement the behavior plan
16. Adjusting environments to decrease the probability of occurrence of the undesirable behavior.

**If appropriate to plan*

Conditions for the use of specific behavioral interventions will be elucidated in the following sections.

POSITIVE BEHAVIORAL THERAPY PROCEDURES

West Bay Rhode Island has adopted a position that gives conditional approval to the following behavioral therapy procedures. These procedures are considered to be widely accepted behavioral practices which are not aversive and which are strongly supported by behavioral theory, research, and current practice. They are considered 'positive approaches' in that the *goal* in using such approaches is to develop and strengthen adaptive, socially appropriate behaviors which facilitate communication, community integration, and social interactions, while minimizing the occurrence of the challenging or problem behaviors.

1. **Alternate Incompatible Behavior Training:** Providing positive reinforcement for behavior determined to be incompatible with the problem behavior
2. **Anxiety Management Training:** Teaching relaxation techniques such as deep breathing and muscle control to aid individuals in identifying and coping with anxiety responses which may be precursive to negative acting out behaviors.
3. **Attentional Training Procedures:** Instructional strategies which use positive reinforcement to establish basic attending responses such as eye contact or focus on a task
4. **Awareness Training:** A discrimination training procedure in which an individual is taught to recognize the presence or absence of a stimulus or behavior known to be antecedent to the problem behavior
5. **Behavior Rehearsal:** Practicing desired behavior in advance of situations known to be setting events for negative acting out behaviors
6. **Chaining:** Breaking a complex task into smaller components and teaching components one at a time, in a specified sequence, using positive reinforcement for successful completion of steps
7. **Communication Skills Training:** Teaching skills to improve ability to express emotions, effectively assert needs and wants, plan activities, resolve conflicts, provide feedback to others, and achieve compromises with others.
8. **Contingency Contracting:** A procedure for behavioral change in which an agreement is made between the person (s) who desire behavior change and the person whose behavior is to change. These are usually written contracts which outline relationships between behaviors and consequences under the agreement.

9. **Contingency Management:** The thorough analysis and change of the contingencies in the environment that determine the individual's behavior with a *goal* of creating conditions which promote desired behavior and minimize the likely occurrence of problem behaviors
10. **Cueing (or prompting):** The presentation of a stimulus to signal the occurrence of a particular behavior or to signal that a certain response will be reinforced in a given situation
11. **Differential Reinforcement:** Providing reinforcement for behaviors other than the problem behaviors or for lower rates of the problem behaviors
12. **Discrimination Training:** Using cues to signal which behavior will be reinforced in a given setting
13. **Fading:** Gradually lessening the cues which have been used to teach a behavior in order to promote maintenance and generalization of the learned behavior
14. **Instructions:** Use of verbal or written cues which describe how to _perform the desired behavior
15. **Modeling:** Teaching a behavior or skill by exposure to another individual performing the behavior or skill
16. **Positive Reinforcement:** Presentation of a stimulus contingent on a behavior which results in an increase in the frequency or strength of a desired behavior. Stimuli used for reinforcement may be tangible, social, or intrinsic reinforcers.
17. **Premack Principle (If...then...):** Reinforcing the occurrence of a behavior less likely to occur by following that behavior with access to a _preferred behavior
18. **Problem Solving Training:** The teaching of effective techniques and behaviors to cope with situations problematic to the individual in his or her social environment
19. **Reinforced Practice:** A facilitative procedure whereby the individual is reinforced for repeating the behavior of a model
20. **Self-Monitoring:** Observing, recording, and evaluating one's own behavior
21. **Self-Verbalization:** Teaching the individual to recognize and interrupt their own maladaptive behavior patterns with reinforcing self-statements
22. **Shaping:** Gradually changing a response by reinforcing successive approximations to the desired behavior
23. **Social Skills Training:** The use of techniques for teaching skills to

increase the social competence of the individual
24. Stress Management Training: Use of techniques to teach skills for coping with stress more effectively
25. Token Economy: A system of positive reinforcement in which reinforcers consist of tokens (tickets, points, etc.) which can be exchanged for desired items or activities

**Definitions are from "Bellack, A & Herson, M (1989). *Dictionary of behavior therapy techniques,* New York: Pergammon Press.

CONDITIONS FOR USE OF AVERSIVE OR RESTRICTIVE PROCEDURES

West Bay Rhode Island recognizes that the implementation of certain behavioral procedures may involve elements of discomfort to the individual. Subsequently, West Bay utilizes the following behavioral approaches to reduce the frequency or intensity of maladaptive behaviors only if consistently implemented in conjunction with positive approaches to strengthen adaptive appropriate behaviors. In addition, these procedures are only used when alternative positive approaches have failed to result in behavioral improvement and when the behavior designated for change is determined to create a potential for imminent risk or harm to the individual or to those around him or her. To assure the appropriateness of these behavioral techniques, West Bay also requires both prior and periodic review and authorization for their use by the following parties:

1. Person receiving treatment (if competent);
2. Legal guardian (if individual is not competent);
3. West Bay Rhode Island Human Rights Committee;
4. West Bay Administrative Authority ;
5. Licensed medical professional
6. Supervising clinician

Procedures shall include safeguards to be implemented including but not limited to:

1. Medical supervision proposed and expected duration, frequency, and precautions to prevent injury.
2. If the person with developmental disabilities shows symptoms of physical injury or distress during the use of any behavioral treatment procedure, the physical injury or distress shall be alleviated. Staff and the person's responses shall be documented.
3. A statement of possible risk, possible side effects, benefits, cautions, and precautions shall be documented, and shall be described to and discussed with the participant and/or parents,

guardian, or advocate, prior to gaining their authorization signatures.

4. Staff shall also have access to a supervisor to determine whether to continue the intervention.
5. Any person receiving behavioral treatment shall have his/her health monitored by a physician or registered nurse over the course of behavioral treatment, as medically indicated. The physician or registered nurse shall document their monitoring activity.
6. Individual records pertaining to the use of behavioral interventions shall be made available for review by the executive director, or equivalent position of the DDO, representatives of the Department, the human rights committee, the participant and/or parent, advocate, or guardian (as appropriate).
7. Any use of restrictive intervention techniques that result in injury to either the participant or any other individual is reportable to the Department.

ACCEPTABLE MILDLY AVERSIVE PROCEDURES
1. Blocking: Prevention of an inappropriate action by physically positioning without actually touching the individual.
2. Exposure: Gradually exposing individuals to low levels of avoided stimuli (such as social situations, travel in automobiles, etc.) in order to promote desensitization and improved quality of experience. Only done when the benefits clearly outweigh the risks and discontinued immediately if resistance or a fear response occurs.
3. Extinction: A procedure in which a reinforcer known to support an undesired behavior is removed.
4. Geographic Containment: Temporarily positioning persons, or objects such as furniture so as to prevent an individual from moving freely in or out of a given area.
6. Physical Prompt Use of any physical contact to guide an individual in emission of any behavior. (see further discussion under 'Emergency Procedures)
7. Response Cost: A procedure in which a routinely accessed positive reinforcer is lost contingent upon behavior. The item lost or removed would never include a personal possession, personal funds, or access to a routinely prescribed activity.
8. Response Prevention: A procedure in which an individual is prevented from engaging in a ritualistic or compulsive behavior known to cause increased

anxiety. This would not include use of physical restraint to prevent a response.
9. Restitution: Requiring an individual to restore the environment to its original condition following an undesired behavior. This would only be done by verbal instruction and would be discontinued upon resistance by the individual.
10. Social Disapproval: Interpersonal interactions such as facial, voice, and language cues which serve as prompts to decrease the future probability of the undesired response.
11. Non-exclusionary Time Out: Discontinuing reinforcement while remaining in the social situation. May include the use of some symbol to signal that an extinction contingency is in effect.

ACCEPTABLE AVERSIVE PROCEDURES TO REVIEWWITH HRC

The following procedures may be considered as treatment interventions under the conditions outlined in the previous *section.*

1. Exclusionary Time-Out from Reinforcement: A procedure whereby the individual is removed to an isolated area with continuous visual monitoring following an undesired behavior.
2. Physical Escort: Using physical prompts or guidance to require a person to move from one area to another (see further discussion under 'Emergency · Procedures)
3. Physical Restraint: Using any form of physical pressure to prevent an individual from moving any part of his or her body. (see further discussion under 'Emergency Procedures')
4. Mechanical Restraint: Using any physician approved device to restrict movement for behavioral purposes

PROHIBITED AVERSIVE PROCEDURES

In accordance with West Bay policy, current standards of ethical behavioral practice, and state laws and licensing regulations, the following aversive interventions are expressly prohibited and will not be considered as viable treatment interventions:

I. Noxious, painful, intrusive stimuli or activities that result in pain, including pinching, hitting, kicking, punching, or slapping.
2. Any form of noxious, painful or intrusive spray or inhalant;
3. Electric shock;
4. Water spray to the face;
5. Pinches and deep muscle squeezes;
6. Application of cold water or cold showers to any part of the body;
7. Emetics for anything other than medical purposes;
8. Corporal punishment;
9. Shouting, screaming, or using a loud, sharp, harsh voice to threaten;
10. Obscene language;
11. Withholding adequate sleep;
12. Withholding adequate shelter or bedding;
13. Withholding bathroom facilities;
14. Withholding meals, essential nutrition, or hydration;
15. Permanent removal of an individual's personal property as punishment;
16. Unobserved time-out or seclusion;
17. Facial or auditory screening devices;
18. Use of chemical restraints instead of positive programs or medical treatments;
19. Withholding or denying of visitation as a form of punishment;
20. Any form of humiliation;
21. Any form of punishment for undesirable behavior when not paired with an approach for reinforcing appropriate replacement behavior;
23. Utilizing law enforcement in place of appropriate therapeutic intervention;
24. Utilizing behavioral interventions for the convenience of staff, or as a result of less than minimum staffing requirements;
25. Specific forms of punishment determined to be overly distressing or aversive including, but not limited to:
Overcorrection (Requiring the person to restore the environment to better than original condition following an environmentally disruptive behavior);

Self-punishment (requiring a person to administer aversive stimuli, including thoughts and images, to themselves following an undesirable behavior;
Vicarious punishment (requiring a person to observe another individual being punished for emission of the undesirable behavior)
NOTE: Occurrence of any of the above will be reportable to the office of Quality Improvement as abuse.

EMERGENCY CRISIS INTERVENTION TRAINING AND PROCEDURES

All employees who provide supports to individuals prone to emergency behavior are trained, by qualified instructors, in appropriate techniques for crisis prevention and intervention. The training at West Bay is based on non-violent crisis intervention for human services models. All employees receive initial training upon hire with, at minimum, annual review. Monitoring of staff performance will be provided by individuals trained and supervised by certified instructors. Personal Safety and Crisis intervention training at West Bay follows this outline: **(*Attachment H: Crisis Prevention Training Outline and Competency)***

I.	Definition of 'Crisis'
II.	Stages of 'Crisis Development'
III.	Review of factors that contribute to 'Crisis Development'.
	A. Verbal behavior
	B. Non-Verbal behavior
	C. Environmental factors
	D. Factors within the individual
IV.	Strategies for avoiding crisis escalation
v.	Planning for and addressing factors outside staff control
VI.	Personal Safety Techniques
	A. Space
	B. Positioning
	C. Safety Stance
VII.	After the Crisis
	A. Documentation
	B. Review for future prevention

CRISIS PREVENTION AND INTERVENTION REGARDING RESTRAINTS

1. Restraints shall not be employed as punishment, for the convenience of the staff, or as a substitute for an individualized plan.
2. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the participant and shall be designed to allow the greatest possible comfort, pursuant to R.I. Gen. Laws § 40.1-26-3(8).
3. Restraints shall be subject to the following conditions:

a. Physical restraint shall be used to protect the participant or others from imminent injury;
b. Chemical or mechanical restraint shall only be used when prescribed by a physician in extreme emergencies in which physical restraint is not possible and the harmful effects of the emergency clearly outweigh the potential harmful effects of the chemical restraints
c. Any restraint that is conducted shall be in accordance with state statute and federal statutes 42 U.S.C. § 290ii(b) and 42 U.S.C. § 15009(a)(3)(B)
Any restraint that is conducted shall also be in accordance with federal regulations42 C.F.R. § 483.420(a); 42 C.F.R. § 483.450(d); and 45 C.F.R. § 1326.19,

Advanced Crisis Intervention Training:

All staff working with individuals who exhibit extraordinary physical acting out behaviors, resulting in more advanced levels of crisis intervention are trained and certified in QBS/SAFETY CARE by certified QBS/SAFETY CARE instructors.
(Attachment I: SAFETY CARE Outline)

POSITIVE BEHAVIORAL SUPPORT EMERGENCY POLICIES AND PROCEDURES

West Bay Rhode Island is committed to providing services in a safe and positive environment and all behavioral interventions are designed with this regard. However, West Bay also recognizes that not all situations or behaviors can be effectively predicted or prevented and that some behavioral expressions may create a situation determined to be an emergency.

Definition of Behavioral Emergency:

West Bay defines a behavioral emergency as any situation caused by an individual's behavior which:

1. Puts that individual or others at imminent risk for grave harm;
2. Is not predictable ;
3. And which occurs less than three times in six months

Emergency Protocol Policy:

West Bay recognizes that the use of physical escorts and restraints represents an extreme response and should only be used in emergency situations by appropriately trained personnel when the danger of the behavior outweighs the risk of the intervention. Physical interventions do not replace effective behavioral interventions and must not be used as punishment. The use of physical escorts and physical restraints is strictly regulated and monitored by state law, licensing and regulatory agencies, and West Bay Services Policy.

In case of behavioral emergency, staff will implement the minimum intervention necessary to maintain safety of all individuals in the environment.

1. If possible, vulnerable individuals will be immediately removed from the area.
2. Staff will implement strategies for de-escalation as outlined in the Behavior Support Plan.
3. If necessary, Staff will attempt to block and redirect the acting out individual as long as they can safely do so.
4. If restraint becomes necessary to preserve the health and safety of the acting out individuals, or others, it will be limited to one or two person escorts from the area, and standing or seated holds. Escort or restraint will be implemented only long enough to interrupt the behavioral chain and allow other opportunities for redirection.
5. If, at any time, the emergency situation cannot be contained with these steps, staff will call 911 and then alert their supervisor that they have done so.
6. Follow Up: The occurrence of an emergency requiring the use of physical escort or physical restraint, or that results in a 911 call and subsequent action, will be followed by appropriate documentation, reporting to appropriate personnel, and a post-situation

review by the supervising clinician and administrative staff of the factors that lead to the emergency situation with consideration of possible future preventative practices to minimize the likelihood of reoccurrence.

Use of Physical Interventions That Are Not Part of an Approved Plan:

Use of physical intervention techniques that are not part of an approved plan of behavior support in emergencies must:

a) Be reviewed by West Bay's Executive Director, her designee, or a physician within one hour of application. Be used only until the individual is no longer an immediate threat to self or others;
b) Be followed by submission of an incident report to QA/1, and the person's legal guardian no longer than one working day after the incident has occurred;
c) Prompt an ISP team meeting if an emergency intervention is used more than three times in a six month period.

Conditions for all Physical Restraints:

If any physical escort or restraint occurs, the following conditions will apply and will be appropriately documented:

1. A lead person will be appointed to direct the escort or restraint;
2. The lead person will appoint an individual to monitor the person's condition during the escort. If there is no other staff available, the lead person will monitor the person's condition;
3. The person being escorted or restrained will be monitored for signs of pain, distress, or anything that signals a life threatening situation including statements of pain, sudden quiet, distressed crying, bluing of the lips or extremities, or any other indication of pain or physical distress.
4. If the above signs are noted, the individual will be immediately released and the situation will be assessed regarding continued intervention.
5. West Bay will not teach or sanction the use of any form of prone restraint or lying across the chest or back of an individual.
6. Documentation of signs and symptoms of physical condition and specific outcomes of behavioral interventions will be provided for each intervention.
7. Occurrence of any restraint or physical escort as part of an approved

Behavior Support Plan will be reported to HRC.

Policy on Prone Restraints

West Bay will not teach or sanction the use of any form of prone restraint or lying across the chest or back of an individual. Any staff who takes it upon his/herself to perform a prone restraint or any other unauthorized intervention will be subject to immediate disciplinary review and action, up to and including termination of employment.

Incident Reporting *(Attachment J: Incident Report)*

Any use of physical interventions shall be documented in an incident report and shall be made available to the department upon request. The reports shall be kept on file for no less than five years and shall include:

1. The name of the Participant to whom the physical or mechanical intervention was applied.
2. The date, type, and length of time the physical or mechanical intervention was applied.
3. A description of the antecedent incident precipitating the need for use of the physical or mechanical intervention.
4. Documentation of any injury.
5. The name and position of the staff member applying the physical or mechanical intervention.
6. The names and positions of any staff witnessing the physical or mechanical intervention.
7. The name and position of the person providing initial review of the use of the physical or mechanical intervention.
8. Documentation of an administrative review, that includes the follow up to be taken to prevent a reoccurrence of the incident, by the Executive Director or her designee.

Copies Submitted

1. The Services coordinator, HRC, or, when applicable, the Department designee will receive complete copies of the incidents.
2. Copies provided to a legal guardian or other service provider must have confidential information about other individuals removed or redacted as required by federal and state privacy laws.
3. All interventions resulting in injuries to any Participant and/or the involvement of law

enforcement must be documented in an Incident Report and forwarded to Ql within one working day of the incident.

4. Any use of aversive behavior techniques that result in injury to either the Participant or any other individual shall be considered reportable to the Department.

New Referrals and Admissions

1. West Bay Rhode Island, Inc. does not teach. sanction or perform prone restraints. Therefore;
2. Should West Bay Rhode Island, Inc., at any time, receive a referral for an individual who is receiving prone restraint in another setting, we will request that the referring agency develop and implement a successful plan to discontinue the prone restraint prior to consideration for admission to West Bay.

POSITIVE STRATEGIES AND INTERVENTIONS TO REDUCE THE ONGOING USE OF EMERGENCY RESTRAINTS OR RESTRICTIONS

As noted throughout, West Bay Rhode Island, Inc. emphasizes the use of proactive, preventative, and positive strategies to and avoids the use of physical restraint and intrusive or aversive procedures. In such extraordinary cases where the behavior is extremely severe or harmful and positive approaches have not been effective, more intrusive emergency interventions may become necessary.

When using emergency restraints or restrictions, our policy and goal is to reduce the use of these interventions through implementation of the following strategies:

1. Ongoing assessment to determine and address function of behavior.
2. Identification and reinforcement of appropriate replacement behaviors.
3. Ongoing training of staff in strategies for prevention and de-escalation of target behaviors.
4. Identification and elimination of environmental factors that might be supporting target behaviors.
5. Identification and treatment of medical or psychiatric conditions that might be supporting target behaviors.

GUIDELINES FOR WHEN THE ISP TEAM WILL BE RECONVENED TO DETERMINE THE NEED FOR THE DEVELOPMENT OF THE INDIVIDUALIZED TREATMENT PLAN FOR A PARTICIPANT

Following the development of an individualized behavior treatment plan, progress is tracked by data collection to measure progress toward goals, and in consultation with the residential team. Data is reviewed at least monthly. The ISP team will be reconvened to determine need for development of the individualized treatment plan when the following circumstances arise:

1. No measurable progress or improvement in target behaviors has occurred following a reasonable period of treatment. This period will be determined by the severity of the behavior of concern, along with the intrusiveness of the behavioral treatment procedure.
2. Treatment of the target behavior is determined to be no longer necessary due to maximum improvement or other determination that treatment is no longer relevant.
3. A review of the treatment plan, and progress, is requested by the participant, the legal guardian, or any concerned advocate.
4. A new target behavior is identified, and after assessment, determined to be cause for further development of the Behavior Support Plan