GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT ON DISABILITY SERVICES

PROCEDURE	
Subject: Restrictive Controls Review Committee	Procedure No.: 2026-QAPMA-PROCXX
Responsible Program or Office: Quality Assurance and Performance Management Administration	Effective Date:
	Number of Pages: 18
Cross References, Related Policies and Procedures, and Related Documents: Home and Community-Based Settings Rule Compliance policy; Behavior Support policy; Behavior Support Plan Oversight procedures; Human Rights policy; Human Rights Definitions; Human Rights Advisory Committee (HRAC) procedure; Provider Human Rights Committee procedure; Health and Wellness Standards; Individual Support Plan policy; Imposition of Sanctions policy; Enhanced Monitoring procedure; Provider Training Policy and Procedure; Person-Centered Modification Procedure; Most Integrated Community Based Setting policy.	

1. PURPOSE

The purpose of this procedure is to establish the process the Department on Disability Services (DDS) shall use to (1) comply with the requirements of the Home and Community-Based Settings (HCBS) Rules; (2) ensure that restrictive controls are used only as a last resort, when other support strategies have been considered/attempted and would not protect the person or others from harm; (3) ensure the health, safety and dignity of each person for whom restrictive controls are recommended; (4) evaluate the technical aspects of programs that include restrictive control procedures; and, (5) delineate the process for reviewing the use of restrictive controls.

2. APPLICABILITY

This procedure applies to all people receiving supports and services from DDS, as well as DDS employees, subcontractors, providers/vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of people with intellectual and developmental disabilities receiving services funded by DDS or the Department of Health Care Finance (DHCF).

3. PROCEDURES

A. RCRC Overview

1. The Restrictive Control Review Committee ("RCRC") is responsible for reviewing designated restrictive controls to ensure people's rights are protected and that the person's behavior support plan conforms to DDS's policies and procedures. Based on the number of people receiving services, the Quality

Assurance and Performance Management Administration (QAPMA), may elect to establish multiple RCRCs that operate independently of each other.

2. Membership

a. RCRC shall have at least three members and three members make a quorum.

b. Members are appointed for a two-year term by the DDS Deputy Director for QAPMA, or his or her designee, and may be reappointed for subsequent terms.

c. In appointing committee members, the DDS Deputy Director for QAPMA, or his or her designee, shall seek representation from the following categories:

1. Nurses or nurse practitioners with expertise in behavior supports;
2. Physicians, including psychiatrists, with expertise in behavior supports;
3. Psychologists with expertise in behavior supports;
4. Licensed clinical social workers with expertise in behavior supports;
5. Allied health professionals (such as occupational therapists, physical therapists, and speech-language pathologists) with expertise in behavior supports;
6. Advocates for people with developmental disabilities (this category includes people that DDS supports but does not include DDS employees or DDS contractors);
7. Other DDS employees at the discretion of the DDS Deputy Director for QAPMA, or his or her designee.

d. In the event of absence, a committee member may have a designated alternate attend and participate in RCRC in the member's stead, with approval from the Rights and Advocacy Specialist (RAS).

3. Responsibilities

a. Committee Members

1. RCRC shall review BSPs to ensure they are person-centered with individually identified goals and preferences, that designated restrictive controls are limited in use and that less restrictive measures have been considered.

2. RCRC shall review BSPs to ensure that the benefits of using restrictive measures outweigh reasonable risks to the person.

3. RCRC members are responsible for staying abreast of and following all DDA policies and procedures pertaining to restrictive controls, BSPs, and

human rights; for attending any required trainings; and for reviewing RCRC packets prior to the meeting.

4. RCRC members will maintain the confidentiality of the people being reviewed and the contents of the plan.

5. Committee members shall actively support people who attend meetings to discuss their BSP and any concerns they may have.

6. RCRC will monitor areas of potential conflict within the committee and ensure members who identify an area of conflict recuse themselves for that particular review.

7. RCRC shall identify any systemic issues that arise for providers, DDA, and/or other government agencies regarding the use of restrictive controls and make recommendations to the DDS Deputy Director for QAPMA.

b. Rights & Advocacy Specialist

1. During the Office of Rights and Advocacy (ORA) pre-review process, the RAS will review BSPs and Requests for Exemption to ensure they comply with DDS policies and procedures within five (5) business days of committal into MCIS. If technical deficiencies are found within the BSP, Request for Exemption, or supporting documents, a consumer issue will be entered for each deficiency. Once all materials comply with DDS policies and procedures, the BSP will be scheduled for RCRC review or the Initial Request for Exemption will be approved, and the issue will be closed.

2. The RAS will review BSPs for compliance with the following content elements:

    a. Does the BSP include observable, measurable target behaviors?

    b. Does the BSP include the most recent twelve months of data for target behaviors, including prosocial behaviors to increase and problem behaviors to decrease?

    c. Does the BSP include demonstrated review of the data by the BSP developer?

    d. Does the BSP include procedures to address behavioral issues consistent with DDA policies?

    e. Does the BSP include a functional assessment?

f. Are there proactive, positive strategies identified in the BSP?

g. Is there a rationale for using the restrictive interventions?

h. Are there benchmarks for reducing the restrictive interventions including a titration plan for medications (or statement of lowest effective dose based on prior attempts to reduce)?

i. Is there a plan for restoring independence from restrictions?

3. The RAS will review BSP exemption requests for the following elements:

   a. Eligibility for BSP exemption based on completion of the Request for BSP Exemption form

   b. Proof of provider HRC approval

   c. Two most recent quarterly psychotropic medication review forms.

4. The RAS, or his or her designee, will develop a packet for committee members to be received as soon as possible before the meeting (preferably 5 business days) that contains:

   a. The BSP;

   b. For update reviews, any additional supporting documentation required per the RCRC's previous recommendations.

5. The RAS shall facilitate RCRC meetings, including emergency reviews, as needed.

6. The RAS, or his or her designee, shall ensure that the person's provider and service coordinator are invited to attend the RCRC meeting and asked to work together to invite the person and support him or her to attend, if he or she would like to participate. The person's provider shall also share information about the review with other members of the person's circle of support and invite them to attend the meeting, unless the person prefers not to share that information.

7. The RAS, or his or her designee, shall follow-up on RCRC meetings, by providing written feedback from the Committee on plans to the person's Support Team via MCIS, and to the Deputy Director for QAPMA or DDS Director as appropriate when the RCRC makes recommendations for corrective action for people, provider or systemic improvements within

five (5) business days of review, or, if applicable, in accordance with the Emergency Review procedures, above.

8. The RAS, or his or her designee, shall maintain documentation of the Committee attendance, proceedings and file and ensure that the record of RCRC meetings include Committee activities, issues reviewed, actions taken, and follow-up requested with timelines.

9. The RAS shall ensure that RCRC practices comply with the process outlined in this procedure.

10. The RAS shall monitor areas of potential conflict within the Committee, ensure members who identify an area of conflict recuse themselves for that particular review, and document both the conflict and recusal.

11. The RAS, or his or her designee, shall manage and validate the database for the purpose of tracking, and to provide the ability to provide trends and analysis. The RAS shall also provide any reports requested by the Deputy Director for QAPMA, DDS Deputy Director for DDA, or the DDS Director.

12. The RAS shall ensure an adequate number of meetings are held each year to prevent a backlog from occurring.

13. The RAS, or his or her designee, shall provide minutes of RCRC meetings to the Quality Trust for Individuals with Disabilities.

14. The RAS shall provide training to Provider HRC committees as needed or at least annually.

15. Each year the RAS shall produce and publish a report that includes a general assessment of the Committee's impact on ensuring and protecting a person's rights over the year and recommendations for change in the coming year. The report shall also include, without any identifying information, the scope of work done by RCRC, trends, and the number and types of recommendations made.

c. DDA Service Coordination

1. The person's service coordinator may choose to participate in the relevant portion of the RCRC review, either in person, by phone or through a Web-based platform.

2. The person's service coordinator shall work with the person's support team to support the person to attend, either in person, by phone or through a Web-based platform, if they would like to participate.

3. The person's service coordinator, working with the person's support team, shall review both the BSP and ISP to confirm that the BSP and ISP are consistent and that one does not contradict the other. The BSP and ISP should work in harmony to appropriately support the person.

d. Provider

1. The person's provider may choose to participate in the relevant portion of the RCRC review, either in person, by phone or through a Web-based platform.

2. Upon invitation to the RCRC by the RAS or their designee, the person's provider shall indicate in writing who is planning to attend the meeting and whether they will attend in person, by phone or through a Web-based platform no later than five business days prior to the scheduled review.

3. The person's provider shall explain the meeting to the person and support them to participate if they would like to do so. The provider should also invite the person's interested family members, substitute decision-maker or Court-Appointed Guardian (if applicable).

4. Operations

RCRC will:

a. Meet weekly, or as frequently as necessary, to ensure all BSPs that require review are reviewed.

b. Make decisions only when there is a quorum.

c. Accommodate members, persons supported, and their substitute decision makers or Court-Appointed Guardians to participate via conference call, or Web based conference platform, if unable to attend in person. Members of the committee who are not able to participate in the meeting may submit comments in advance for consideration, but they will not count as in attendance for the purpose of a quorum.

d. The RAS, or designee, as the RCRC Facilitator, shall coordinate RCRC meetings, but does not count for the purpose quorum.

e. The RCRC shall take immediate actions, as necessary, to protect the human rights, health and safety of people served. Such actions may include, as appropriate, the following:

1. Suspending any BSPs that are not developed, implemented, documented, or monitored in accordance with this policy or where significant trends and patterns in data suggest the need for further review;

2. Offering technical assistance on the development of a new BSP; and/ or

3. Recommending training by the Rights and Advocacy Specialist (RAS) for the Provider's HRC or provider staff.

f. The RCRC shall make recommendations to providers for policies, procedures, practices and/or strategy changes that lead to reduced restrictive controls and more effective behavioral supports.

g. The RCRC shall make recommendations to the DDS Deputy Director for QAPMA for corrective actions, including sanctions, technical assistance, and training for providers who inappropriately use restrictive controls.

B. Behavioral Support Plan Review

1. BSPs Subject to RCRC Review

BSPs that meet one or more of the following criteria must be submitted to RCRC for review:

a. BSPs involving individualized staffing due to behavioral health concerns. Participation from the IDT is mandatory to discuss justification for the proposed restriction at the RCRC review or the BSP will be removed from the agenda.

b. BSPs involving the use of physical restraints.

c. Requests for individualized housing for a person due to behavioral health concerns. Participation from the IDT is mandatory to discuss justification for the proposed restriction at the RCRC review or the BSP will be removed from the agenda.

d. BSPs for people who are prescribed psychotropic medications that affect or alter thought processes, mood, sleep, or behavior, when there is not a provider HRC to review the plan.

e. BSPs containing restrictive controls for people residing in Intermediate Care Facilities (ICFs).

f. BSPs that call for the use of medical sedation on a regular basis, as deemed necessary by a physician, in order for the person to receive needed medical services without delay. NOTE: A one-time use of medical sedation does not require a BSP but must be entered as an incident in the MCIS incident management system.

g. BSPs containing restrictive controls such as curfews, restitution plans or modifications to the Home and Community Based Settings Rules that are not covered by the Person-Centered Modification Procedure.

h. BSPs that involve the use of any other restrictive control.

i. Any BSP or request for exemption that is referred to the RCRC by the person, a member of the person's support team, or by the provider HRC.

2. **Conditions Requiring RCRC Review**

Should a person's BSP meet the above criteria, RCRC review must also occur in any of the following situations:

a. Prior to the initiation of any new restrictive control(s). This does not include changes to psychotropic medications prescribed by the persons health care provider;

b. At the time designated by the RCRC or upon request of HRAC, RCRC, or the DDS Psychotropic Review Panel;

c. Upon request of any member of the person's support team, including the person;

d. When a change in condition has occurred for a person with a BSP exemption that necessitates the development of a BSP; or

e. When court-ordered restrictions or conditions are imposed on the person.

3. **BSP Exemption**

People prescribed only one psychotropic medication may request from ORA an exemption from having a BSP. However, people residing in ICFs are not eligible for BSP exemption.

4. **BSP Timelines**

a. The annual BSP and supporting documentation must be uploaded at least 60 calendar days prior to the effective date of the Individual Support Plan (ISP).

b. The Office of Rights and Advocacy (ORA) or their designee will conduct a pre-review within seven (7) calendar days of receiving the notification that the BSP has been uploaded.

c. The provider will have 15-30 calendar days to upload documentation to resolve/close any issues resulting from the BSP pre-review and ORA will review the documents within 3 business days of receipt to close the issue or request additional documentation from the provider if needed.

d. The RCRC meeting to review the BSP will occur at least 20 days prior to the ISP/BSP effective date.

e. ORA will enter a note within one (1) business day of the RCRC meeting.

5. **BSP Review Criteria & Review**

Approval of BSPs will be based on the following criteria:

a. BSP incorporates person-centered practices and trauma informed supports;

b. Restrictive controls are used only as a last resort, when less restrictive strategies and positive supports have been considered or would not protect the person, others, or property from harm;

c. Proactive, positive strategies have been considered/ attempted to increase quality of life and decrease problem behavior by teaching new skills and making changes in the person's environment.

d. Sufficient rationale is provided for the use of each restrictive control based on reasonable risks and benefits to the person;

e. Adequate benchmarks are identified for reducing the use of each restrictive control and for "restoring independence" from restrictive controls;

f. Sufficient justification exists for the use of physical interventions that may be implemented for the person, taking into account the behavior, the person's age, size, medical diagnoses, personal history of trauma and abuse, and the urgency of the situation;

g. The BSP describes the role of staff to provide crisis interventions, including contacting available community resources, to resolve the immediate crisis and prevent future crisis episodes;

h. When psychotropic medication(s) are used, the BSP includes goals for medication titration;

i. The BSP contains positive strategies to enhance the person's skills and independence;

j. The BSP preserves people's rights to self-determination and choice;

k. The BSP is consistent with established DDS policies and procedures;

l. Additionally, Intellectual Disability and Autism Spectrum Disorder (autism) are excluded from the statutory definition of mental health disorders in the District of Columbia. Therefore, the use of psychotropic medication for people with intellectual disabilities or autism is prohibited by DDS's Behavior Support Policy unless the person also has a diagnosed mental health disorder. If a person with an intellectual disability or autism is prescribed psychotropic medication without a formal psychiatric assessment and diagnosed mental health disorder, implementation of the physician's order for psychotropic medication should continue without disruption while working with the person's prescriber to come into compliance with the DDS's Behavior Support Policy. Full approval of these BSPs by RCRC will be deferred until the BSP is revised to indicate a co-occurring mental health disorder in addition to autism or Intellectual Disability.

6. **Following Review**

After reviewing and discussing each BSP and supporting materials, the Committee shall approve, defer or reject each plan. The RCRC may also make recommendations for changes to the contents of the BSP to ensure that the BSP comports with DDA policy and that the interventions used are the least restrictive and most appropriate interventions to meet the person's behavioral support needs.

a. The Committee may "approve" a BSP that meets all of the RCRC review criteria.

b. The Committee may "defer" a BSP when it does not include all of the information needed for the review to answer the review criteria in the affirmative. For plans that are deferred, the Committee shall make specific recommendations about information needed and set a date for an update review by RCRC or RAS. Depending on the recommendations, restrictions that are determined by RCRC to be necessary for safety may be approved, for a finite period, while awaiting the updated plan.

c. The Committee may "reject" a plan when the committee determines that the plan does not meet the review criteria or would be unsafe to implement. For plans that are rejected, RCRC shall make specific recommendations for improvement and set a date for the revisions to come back to the Committee for an update review. The proposed restrictions, except the use of psychotropic medications, cannot be implemented, unless otherwise specified in the RCRC recommendations.

d. The Committee shall align the BSP expiration date with the expiration date for the person's Individual Support Plan ("ISP").

7. Time Limits on RCRC Approvals

RCRC approvals are time limited.

a. BSPs that include the use of psychotropic medications as the only restrictive control may be approved for up to two years from the annual ISP expiration date.

b. BSPs that include individualized housing for behavioral reasons, individualized staffing supports or any other restrictive control (except for psychotropic medication), shall be approved for 1 year from the annual ISP expiration date.

c. Provider HRCs are required to review BSPs on an annual basis, or as needed, even if they have been approved for two years by the RCRC. The provider HRC shall determine that there are no material changes to the plan requiring the development of a new plan.

1. If no material changes, the provider shall communicate with the BSP developer to update the date of the BSP, and then re-load the BSP and the provider HRC review into the BSP section of MCIS.

2. If material changes to the BSP are required, the provider shall communicate with the BSP developer to update the BSP, re-submit for provider HRC approval, and notify the Office of Rights and Advocacy (ORA) that there is a new plan requiring review by the RCRC by committing the BSP and all supporting documents into MCIS.

C. Emergency RCRC Review

1. Any member of the person's support team or the RAS may request an urgent or emergency review of a BSP that includes a restrictive control.

2. Emergency reviews will take place within five business days of the request.

3. Upon request for emergency review, the RAS will facilitate an expedited RCRC review by:

   a. Coordinating a meeting or conference call with at least three (3) members of the RCRC within five business days;

   b. Ensuring each committee member has the opportunity to review the BSP and all supporting documentation; and

   c. Inviting the person and members of their support team to participate in the review.

4. After expedited review, RCRC may approve, defer, or reject the BSP or targeted restriction(s). The RAS or RCRC facilitator will enter the minutes of the review into the BSP section of MCIS.

D. Temporary or Emergency Approval of Individualized Staffing for Behavior

1. General

   The Restrictive Control Review Committee may grant a one-time 45-day temporary, or emergency, approval for individualized behavioral staffing for a person who:

   a. Has never had a BSP and has experienced a significant change in their life necessitating individualized behavioral staffing for safety;

   b. Has a current BSP that does not include individualized behavioral staffing, but the person has experienced a significant change in functioning that necessitates an increase in staffing for safety.

   c. Had a BSP in the past, but it was discontinued or they were previously exempted from having a BSP and they have now experienced a significant change in their life necessitating individualized behavioral staffing for safety; or

   d. Does not currently have a BSP and is transitioning to community-based services from a secure setting (for example, jail, psychiatric hospital, or residential treatment facility) and the support team anticipates the person will need individualized behavioral staffing for safety while a BSP is being developed.

2. Requests for individualized behavioral staffing will be reviewed by RCRC at the next scheduled meeting date. Requests approved by RCRC shall be considered as temporary while the support team clarifies a person's behavior support needs and works to obtain those services. While this staffing may be necessary for some people we support, it is not intended to bypass efforts to identify and address the underlying causes of the challenging behavior (i.e., through behavior support technical assistance, retraining on the BSP, case conference, review of person-centered programming, medication adjustments, psychiatric consultation, etc.).

3. If approved, individualized behavioral staffing is for 45 days only. Providers may not request more than one 45-day approval at a time.

4. Providers not approved by RCRC for one-time 45-day individualized staffing cannot provide the service as it is a violation of this procedure.

5. Requesting emergency or temporary approval for individualized behavioral staffing:

    a. To request emergency or temporary approval for individualized behavioral staffing for a person *who currently has a BSP or has had a BSP in the past,* the provider must enter the request through MCIS by doing the following:
        - Select the person's name from the name roster.
        - Go to the "Person" tab.
        - Click the BSP section under the "Medical Info" section on the left-hand side of the screen.
        - Click on the BSP marked "Current."
        - Click "Edit" to open that version of the BSP.
        - Click on "45-Day Temporary BSP Requests", at the top right corner of the screen.
        - Choose one of the following five options that justify the need for the temporary individualized supports:
            i. Has never had a BSP and has experienced a significant change in their life necessitating individualized behavioral staffing for safety;
            ii. Has a current BSP that does not include individualized behavioral staffing, but the person has experienced a significant change in functioning that necessitates an increase in staffing for safety.
            iii. Had a BSP in the past but it was discontinued, or they were previously exempted from having a BSP and they have now experienced a significant change in their life necessitating individualized behavioral staffing for safety;
            iv. Does not currently have a BSP and is transitioning to community-based services from a secure setting (for example, jail, psychiatric hospital, or residential treatment facility) and the support team

anticipates the person will need individualized behavioral staffing for safety while a BSP is being developed.

v. Other (If "Other" is chosen, the provider will need to provide a justification for the temporary approval.)

b. To request emergency or temporary approval for individualized behavioral staffing for a person *who has never had a BSP*, the provider implementing behavior support services should submit the request to ORA via email. The email request must answer the following six questions:

1. What less restrictive actions have been taken to keep the person and those around him or her safe without individualized behavioral staffing?
2. What is the potential danger to the person, property, or others if individualized behavioral staffing is not in place?
3. What will the 1:1 staff do? Describe the specific interventions the 1:1 staff will carry out that are unique from what regular staff would do.
4. Why can't the person be supported with the existing staffing ratio?
5. If individualized behavioral staffing is being requested for the overnight hours, what is the justification for overnight staffing?
6. Is this an emergency request?

ORA will respond to the request within five (5) business days. If approved, an authorization for individualized staffing will appear in the BSP section of MCIS.

6. Provider Responsibilities Upon Approval of a 45-day Temporary Approval of Individualized Staffing

a. A BSP must be developed by a qualified clinician. The BSP must incorporate individualized staffing for behavior and the corresponding behavior support duties of the staff.
b. The person's support team must work with the person and their substitute decision maker, or court appointed guardian (if applicable) to obtain informed consent for implementation of the BSP and for each restrictive control in the BSP, including psychotropic medication.
c. The BSP clinician must conduct training on the BSP for any member of the support team who supports the person more than one hour per week on a regular basis.
d. The provider HRC shall review and approve the BSP. If the provider HRC does not approve the BSP, the provider must work with the BSP clinician to revise as necessary for the HRC's approval.

e. The provider that is implementing the BSP must commit the BSP and all supporting documents (listed below) into MCIS to alert the RAS that the documents are ready for RCRC review.
f. Documentation includes the following:
    1. Informed consent for implementation of BSP.
    2. Informed consent for psychotropic medications (if applicable).
    3. Evidence of staff training across all settings (as applicable).
    4. Evidence of provider HRC approval.
    5. Most recent three months of behavioral data across all settings (as applicable).
g. Two most recent quarterly psychotropic medication reviews (as applicable).

The provider has 45 days from notification within MCIS of temporary approval to provide the above-mentioned documentation. Documentation not completed within this period will be entered as a provider/consumer issue within MCIS for an unmet need.

E. Appeal Rights

1. A person receiving DDA services may appeal a decision of the RCRC in writing within 30 business days of that decision. Representation by an attorney, advocate or other non-legal representative is allowed, but not required. The person may submit an appeal to the DDS HRAC or directly to the DDS Deputy Director for QAPMA. Should the person first seek HRAC for review of an RCRC determination, that person retains the right to appeal the HRAC's determination to the Deputy Director for QAPMA. An appeal of the HRAC determination must be made in writing within 30 business days of that determination.

2. The HRAC shall review the decision at the next meeting and, in no more than 30 calendar days. Recommendations by the RCRC to approve any restrictive control or limitation on a person's individual rights shall not be implemented while an appeal is pending, unless failure to implement would result in imminent risk to the health and/or safety of the person or others around them. Psychotropic medications shall be implemented when prescribed.

3. The DDS Deputy Director for QAPMA will provide a final, written administrative decision within 30 calendar days to the person and his or her Support Team, if appropriate. If the final written decision upholds the RCRC or HRAC decision, it will outline the additional steps a person could take to seek redress, including referral information.

F. Restrictive Controls Guidance on the Use of Physical Restraints

1. Requirements for BSPs That Involve the Use of Physical Restraints

The following components must be addressed in BSPs that include the use of physical restraints:

a. The person's BSP must include detailed descriptions of each physical restraint technique that will be used for safety in a crisis situation.

b. The BSP must describe when the use of physical restraint will be initiated, the name of the physical restraint used, the maximum duration of time that each physical restraint hold can be applied, and specific instructions about when the restraint should be discontinued.

c. Providers must obtain annual documentation of medical clearance from their primary care physician verifying that the person does not have any medical conditions that would make the use of restraint contraindicated. Even if medical clearance is provided, RCRC may still reject the use of physical restraint in the BSP if it is not clinically justified.

d. Illustration(s) of the techniques or holds must be attached to and remain with the plan.

2. Approved Crisis Support Programs

a. DDS recognizes two specialized instruction programs for crisis support: Nonviolent Crisis Prevention and Intervention (CPI) and the Mandt System (MANDT). CPI and MANDT emphasize communication strategies, relational skills, and nonverbal communication strategies for use during acute behavioral episodes. Training in CPI and MANDT also includes competency-based training in the use of physical restraint interventions when nonphysical interventions are insufficient. The initial training and recertification in CPI or MANDT must be conducted by a live certified trainer, but technology may be used in conjunction with live training. Staff must be recertified in CPI or MANDT annually or more regularly at the request of the RCRC.

b. Residential and day staff who are expected to implement physical restraint interventions as part of the BSP must maintain 100% competency in between annual recertifications. Provider training records uploaded with the BSP for RCRC review must document that staff have demonstrated 100% competency in the appropriate use of CPI or MANDT each time they are trained on the person's BSP.

c. DDS providers in states that mandate the use of crisis management programs other than CPI or MANDT are required to consult with the RCRC to ensure that prohibited crisis intervention procedures are not being used.

3. Guidelines for the Use of Approved Physical Restraints

a. Physical restraint may only be used under the following conditions:

   1. When there is a credible and immediate threat of harm to self or others. It is not intended to change behavior where there is no protective need.

   2. When less restrictive methods of intervening have not successfully mitigated the danger to the self or others.

   3. When the danger presented by the target behavior outweighs the risks of physical interventions.

b. The use of physical restraint is limited to a cumulative total of 15 minutes within a two-hour period. After 15 cumulative minutes within two hours, the provider shall call 9-1-1 and/or follow the guidance in the person's Behavior Support Plan (BSP) crisis plan. The longer the application of physical restraint continues, the more dangerous the crisis situation becomes.

c. If the person demonstrates a need for medical attention in the course of a physical restraint, medical priorities shall supersede behavioral priorities. The use of restraints should be terminated immediately, and the person shall receive immediate medical attention.

4. Post-Restraint Requirements

   a. Medical Assessment

      A medical assessment must be completed by an RN or physician within one hour after the use of physical restraint and again within the next 24 hours to evaluate the person for changes in health condition that require medical attention. The assessments may be conducted by a provider nurse, by medical staff at an emergency room or urgent care clinic, or through a telehealth evaluation.

   b. Debriefing

      A post-restraint debriefing must be completed within 24 hours to review the circumstances that precipitated the use of physical restraints; non-physical interactions used to attempt de-escalation and response; what worked and what could have been done differently; strategies that might have prevented the use of restraints; strategies to prevent any recurrence of the use of physical restraints; and the outcomes of the use of physical restraints, including injuries.

5. Prohibited Physical Restraint Practices

a. The use of any physical restraint that is not time limited. Restraints must be removed as soon as the person is no longer an immediate danger to self or others.
b. Prone (face down) restraint.
c. Any restraint that restricts breathing.
d. Physical restraint that places the person on the floor.
e. Physical restraint that places the person on the floor or any other surface with staff on top of the person.
f. Physical restraint that relies on pain for control.
g. Physical restraint that relies on a take-down technique in which the person is not supported and allows for a free fall to the floor or another surface.
h. Any physical restraint that is not part of CPI or MANDT.

G. Sanctions

DDS may impose sanctions on providers who do not comply with this procedure in accordance with the DDS Sanction Policy.