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**Commonwealth of Virginia**

**Department of Mental Health, Mental Retardation  
and Substance Abuse Services**

**NORTHERN VIRGINIA TRAINING CENTER  
PLAN**

**As revised through**

**June 27, 1996**

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**Department of Mental Health, Mental Retardation  
and Substance Abuse Services**

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PLAN**

March 13, 1995

**As revised through  
June 27, 1996**

This Plan has been prepared by the Northern Virginia Training Center (NVTC) in response to concerns raised by the United States Department of Justice (DOJ) in connection with its investigation of NVTC under the Civil Rights of Institutionalized Persons Act (CRIPA), and following its original tour of NVTC. The Plan is incorporated by reference into the Settlement Agreement executed by the Commonwealth of Virginia and the United States of America, and is subject to the terms thereof.

## **I. DEVELOPMENT AND IMPLEMENTATION OF TRAINING PROGRAMS UTILIZING POSITIVE TRAINING TECHNIQUES**

NVTC provides training programs developed by qualified professionals utilizing positive training techniques designed to afford skill development, personal safety and reasonable use of restraints and prevent regression of residents. In order to accomplish these programs, NVTC will:

A. By July 1, 1996, NVTC will professionally evaluate and/or re-evaluate each resident using multi-disciplinary evaluations, as needed. Each individual will receive a psychological review or comprehensive evaluation as part of the development of his or her annual habilitation plan. The annual review will consist of a review of previous evaluations to determine continued validity, review of the client's chart, observations of the client, report of behavioral treatment, behavioral data, comparison of the current service period with the previous one to determine relevant changes, and statements concerning a person's needs and recommendations for treatment. If a significant change is noted in the individual, the ID Team will request additional information and the psychologist will provide the necessary evaluations. Full psychological evaluations will be completed for clients every three (3) years, or more frequently if conditions warrant. A full psychological evaluation will include a concise description of the resident, an appropriate assessment of intellectual/cognitive functioning and adaptive behavior, assessment of mental health problems (if appropriate), review of previous evaluations and comparison of the current test results with previous results to determine trend, review of behavioral observations, review of behavioral procedures and data, the resident's strengths, needs and the psychologist's recommendations. These evaluations will focus on the assessment of functional skills and interests through ecological and person-centered assessment procedures. Each assessment will coincide with each client's annual Individual Habilitation Plan (IHP) schedule.

1. By August 1, 1995, all current and future admissions to the Special Behavior Unit will receive a functional assessment. (Attachment 1). A widely used functional assessment tool developed by Robert Horner and colleagues, called Functional Analysis of Problem Behavior, will be used as a primary assessment guide. Other assessment tools, such as the Aberrant Behavior Checklist, the Psychopathology Instrument for Mentally Retarded Adults, the Reiss Screen, the Autism Behavior Checklist, and ecological and analog assessment strategies will also be employed as needed.

2. By March 1, 1996, all clients receiving psychotropic medication and/or restrictive behavior support plans will receive a functional assessment as part of their individualized behavioral support plan. A functional analysis will be conducted thereafter as needed, at least on an annual basis.



3. The Director of Center Programs is developing a training curriculum for the psychology staff with specific training in functional and ecological assessment and the use of this information in the development of positive behavior support plans. A major focus for all persons will be on teaching more appropriate skills to replace challenging behaviors. The first training class is planned for August 1, 1995 and training will be completed by March 1, 1996.

4. Every client for whom a behavioral need is identified or who has a behavioral program will receive a formal functional analysis as part of the development of a behavioral support plan by July 1, 1996. In developing and assessing behavior plans, priority will be given to those individuals whose behavior places them at greatest risk. NVTC will establish priority for program development for those residents who exhibit Pica, self-injurious behavior or other behavior that is dangerous to self, others, or property and for those residents for whom relatively high usage of time-out and/or restraint is shown by objective and reliable data. Such individuals will receive functional analyses which are focused on assessing the specific problems demonstrated by the individual. Behavioral plans will be based upon objective and reliable data and interventions documented in those plans will be based upon data collected. When appropriate, current literature will be considered in developing behavior plans.

B. NVTC will continue to develop and implement a professionally based training program for each client and provide each client with an adequate number of hours of training pursuant to applicable standards utilizing positive approaches to enable the client to develop behaviors which will afford safety, freedom from undue restraint and other restraints on the individual's movement within and about the facility and to prevent regression or deterioration of skills. By July 1, 1996, each training program will contain at a minimum:

1. Training objectives developed by an appropriately constituted interdisciplinary team and based upon assessments and evaluations required by paragraph 1 above for those clients who have been identified as needing mental health services, which comport with applicable standards;

2. Specific instructional methods to be utilized by those with responsibility for implementing the program; such methods will emphasize positive approaches and positive behavioral interventions which promote functional skill development and socially acceptable behaviors for the individual client;

3. A specific training schedule to be followed; the number of hours of training to be provided will be sufficient to permit the client for whom the

program has been developed to have a reasonable opportunity to reach the identified behavioral objective(s) of a training program; no schedule will provide for fewer than 40 hours of structured training or activities each week, unless medically contraindicated;

4. Procedures utilized for data collection will be sufficient to permit a qualified professional to evaluate the effectiveness of the training program or any part thereof and to monitor the implementation of the plan and ensure its modification, as necessary. Documentation forms for tracking adaptive and maladaptive behaviors have been standardized. A computerized data tracking system is being used to provide on-going functional assessment of behavior plans. Graphical representations of the data are and will continue to be presented to the Behavior Management Committee (BMC) and Local Human Rights Committee (LHRC) and are used for clinical presentations; and

5. Identification of the persons responsible for the consistent implementation of the program.

C. NVTC will consistently implement the training programs required in Paragraph B. above for all clients by July 1, 1996, and thereafter within fifteen (15) days of the development of the behavior plan by the ID team and full approval by the Behavior Management Committee (BMC), Local Human Rights Committee (LHRC) and parent/guardian. Notwithstanding this time frame, priority in the development and implementation of training programs will be given to any client exhibiting self-injurious, aggressive or pica behaviors. Any such client will have a professionally developed and consistently implemented training program within sixty (60) days of identification of the problem.

D. In order to afford consistent implementation of training programs, NVTC provides and will continue to provide adequate competency-based training for all staff responsible for implementing the programs specified in Paragraph B above. Staff training will focus on how to implement the programs and collect appropriate data. NVTC will conduct regular periodic follow-up evaluations of staff competency in implementing programs and provide additional training, as necessary.

1. By June 1, 1995, center-wide Psychology Behavioral Treatment Books will be available to all psychology staff, advocate, duty officers and roving team leaders. Also by June 30, 1995, Unit-specific Behavioral Treatment Books will be accessible to all unit staff as a reference for behavioral support plans.

2. Greater emphasis upon the preventive and positive procedures of the "Mandt" Training System have been included in staff orientation and during staff training of individualized behavior support plans. The entire staff

orientation training package for behavior management was reviewed in January 1995 and plans and timelines for a revised training package based upon preventive and positive behavioral support program philosophies and procedures have been established. Implementation of the revised training package is set for August 1, 1995.

E. NVTC has implemented and will fully maintain systems by March 1, 1996 for: (1) observing clients' behavior to determine the effectiveness of the programs and recording those observations; (2) verifying the reliability of the recorded data; and (3) ensuring that a qualified professional reviews and appropriately modifies any client's training program when the professional determines that the resident has exhibited no measurable progress for a significant period of time.

1. Unit-based clinical meetings will continue to occur semi-monthly to monitor clinical issues and address changing client needs. In the Special Behavior Unit (SBU), these meetings will occur weekly.

2. Unit-based psychotropic medication/behavior plan reviews will continue to occur weekly on the SBU and on all other units at least monthly. This interdisciplinary data-based review is attended by the psychiatrist, physician, psychologist, psychological assistant, nurse, direct care staff, program manager or team leader, and Qualified Mental Retardation Professional (QMRP). Vocational staff, parents and other pertinent professional disciplines may also attend.

3. Psychology staff will perform weekly reliability checks of treatment plans using direct observation of client behavior and implementation of behavior support plans by direct care staff. Documentation of behavior support plans will also be checked for reliability on a weekly basis by comparing direct care staff and client observations with log entries, behavior tracking forms, and entries in the client record by March 1, 1996.

4. QMRP's will continue to provide program monitoring at least quarterly as part of the Individualized Habilitation Plan (IHP) review system.

5. Active treatment will continue to be formally monitored using a system designed by Dr. Brian Iwata. Designated and trained staff will record observations at least twice a week for every unit. (Attachment 2). In January 1995, a data system was established in which active treatment information from this form will be used to make management decisions. The Risk Manager will enter the raw data and monthly reports will be generated for review by management staff. Active treatment and other measures will be integrated into a program monitoring plan to be submitted to the Quality Management Committee by August 1, 1995. The results of these measures

will be compiled and distributed quarterly to all clinical and unit departments and to the Quality Management Committee.

F. NVTC will develop by January 1, 1996, a system to regularly train all direct care staff in collecting and maintaining the behavioral data necessary to assess the effectiveness of any behavior program. Staff will be fully trained by July 1, 1996. NVTC will keep written records to document such training.

G. An interdisciplinary team will evaluate the efficacy of the training programs for each client with self-injurious, aggressive or pica behavior on a monthly basis and the efficacy of the training programs for all other clients on at least a quarterly basis. The team will base its review of the efficacy of the training programs on the data collected as well as the occurrence of incidents (events) and the use of restraints. If the team recommends the need to revise the training program, it will be reviewed and revised, if appropriate, by a psychologist within thirty (30) days.

H. The Behavior Management Committee, including the Director of Medical Services and, as appropriate, a psychiatrist, will review behavior plans and supporting documentation relating to each resident who: (1) exhibits self-injurious or aggressive behavior, or (2) is subject to restrictive programming, frequent behavior control procedures, or receives behavior modifying medication, to ascertain whether: (i) there are sufficient behavioral data recorded, (ii) such data have been assessed for reliability, and (iii) the continuation of the current training or treatment program is justified, or the program, including medication, should be modified. Where inadequate or unreliable data are found, or the continuation of the training or treatment program is otherwise not justified, the matter will be referred to the appropriate interdisciplinary team which shall, within 30 days of the referral, modify the existing program in accordance with the judgment of qualified professionals, including the primary care physician, psychologist and psychiatrist, as appropriate. When in the judgment of qualified NVTC professionals, data indicates that individual programs as implemented have been ineffective and outside independent consultation is necessary to assist in devising an appropriate revision to the program, NVTC will obtain such consultation.

## **II. USE OF PHYSICAL RESTRAINT AND TIME OUT**

NVTC has developed and will continue to implement policies and procedures to ensure that time-out and physical restraints are administered only pursuant to the judgment of a qualified professional and are not used as punishment, in lieu of training programs, or for the convenience of staff. These policies and procedures are contained in NVTC Instruction 5300 (Restrictive Procedures) and NVTC Instruction 5301 (Use of Protective Devices) and the Psychology Department's Behavior Therapy Procedures: Philosophy of

Use, Definition and Staff Responsibilities. (Attachments 3, 4, and 5). These policies and procedures will:

- A. Protect clients from unreasonable risks to their personal safety from both the conduct of staff and other clients, and from unreasonable use of bodily restraints.
- B. Provide for the use of bodily restraint and time-out only in conjunction with a written treatment and/or training program, except in emergency circumstances. An "emergency" is defined as "a situation in which a qualified professional deems a behavior to be likely to cause harm to the client or others or to property unless the proposed intervention is immediately initiated." For each emergency use of bodily restraint or time-out, the decision to use the bodily restraint or time-out must be made by a qualified professional after considering a hierarchy of less restrictive interventions. Each emergency use of bodily restraint or time-out will be described and recorded in the client's record including the identity of the professional making the decision and the justification for the decision. A client who has been placed in time-out or bodily restraints in emergency circumstances three times in the previous year will be assessed and a written treatment and/or training program developed, if necessary, within two weeks of the third incident, except in medical contingencies where the restraint is prescribed by a physician for short term use while the condition is being treated. A standardized Crisis Management Documentation Form has been used since January 1994 to track emergencies and will continue to be used.
- C. Require that, in every behavior program that utilizes bodily restraint or time-out, specification of:
  - 1. the behavior to be eliminated and the specific behavior, clearly and objectively defined, which triggers the use of the restraint or time-out;
  - 2. behaviors to be taught to the client to replace the behavior that initiates the use of the restraint or time-out and other programs to reduce or eliminate the use of such restraint or time-out;
  - 3. the restriction, i.e. type of restraint or time-out authorized and, where applicable, the duration of the restriction;
  - 4. the professional responsible for the program and the direct care staff authorized to implement the program;
  - 5. the frequency and manner in which behavioral data are to be recorded by direct care staff.

In order to accomplish the above, NVTC has revised the format of all behavior support plans (BSPs). A major emphasis is placed on functional analysis-based

treatment plans which rely upon individualized preventive and proactive behavioral procedures to address challenging behaviors. (See Attachment 6 for a sample of this new format.) A short summary of each BSP is also written to be used as a quick, easy reference for staff. All behavior plans and short summaries will be rewritten into this new format corresponding with the client's annual staffing. All BSPs will be written into the new format by January 31, 1996.

D. Require that beginning January 1, 1996, any treatment and/or training program utilizing bodily restraint or time-out will be reviewed before implementation and at least every three (3) months thereafter by the Behavior Management Committee (BMC) as well as by the Local Human Rights Committee prior to implementation of the program; provided, however, that under emergency conditions, the Chairman of the BMC may approve a program not to exceed 30 days.

E. Prohibit the use of bodily restraint or time-out except in: (a) those situations where there is written evidence in the client's record that other, less restrictive techniques have been considered and/or systematically tried and consistently implemented as part of a professionally designed training program and accurate, objective data have demonstrated such techniques to be ineffective and (b) emergency situations in which there is a risk of harm to self or others. Each time a device is used in an emergency situation or as a protective device, the client record must document that the decision to so use the device was made by a qualified professional; it must identify the professional making the decision, and it must document the justification for such use. Any use of restraint will be the least restrictive form of restraint after consideration of a hierarchy of less restrictive interventions. The use of papoose boards as a form of behavioral restraint was eliminated as of January 18, 1992 and will not be re-implemented. There are and will be no standing medical orders for PRN psychotropic medications.

F. Require that appropriate psychology staff will review monthly each use of bodily restraints or time-out occurring in the previous 30 days to ascertain whether each use was pursuant to the exercise of professional judgment or the behavior program of the resident subject to the use. The results of these monthly reviews, including the conclusions of the psychology staff, will be reported to the BMC every three (3) months, which will review whether a particular client needs a behavior program or whether an existing program should be modified. The BMC may initiate more frequent reviews when indicated. Restrictive measures will be continued in clients' programs only if reliable data supports the necessity of their continued use. The BMC will record these recommendations and transmit them to appropriate staff, as well as NVTC management, who will be responsible for ensuring that any new programs or revised programs are developed and implemented within 30 days.

### III. STAFFING REQUIREMENTS

NVTC will hire, deploy, and provide ongoing training to a sufficient number of competent and qualified direct care and professional staff to provide its clients with adequate care, treatment, and training programs.

A. A sufficient number of qualified staff, including physicians, psychologists, registered nurses, licensed practical nurses, registered physical therapists, licensed physical therapy assistants, occupational therapists, speech therapists, dietitians and direct care workers will be available. NVTC will demonstrate continuing efforts to achieve any additions to staff that are necessary for this purpose by January 1, 1996 and will achieve such staffing by July 1, 1996.

B. NVTC will maintain adequate direct care staffing levels while implementing its census reduction plan referenced in Section XI.A. below. NVTC currently meets an on duty direct care ratio of 1:4 on the a.m. shift, 1:5 on the p.m. shift and 1:9 at night. When the client census reaches 200 on July 1, 1996, NVTC will have and maintain a campus-wide staffing ratio of 1:4, 1:4, 1:8 and will continue to deploy staff based on the exercise of professional judgment to provide for the training and safety needs of all clients. NVTC will continue to provide 1:1 staffing for individuals whom qualified professionals at the facility have determined are in need of 1:1 staffing.

C. Direct care staff will not be routinely used to perform such support functions as housekeeping, laundry, other than client personal clothing, maintenance and meal preparation, etc. This requirement does not preclude direct care workers from training residents in these functions pursuant to a written training program developed in accordance with established procedures.

D. NVTC will employ sufficient senior clinical staff to afford adequate clinical supervision, case consultation, education and training of staff and to afford the provision of adequate services to clients.

E. NVTC will continue to employ as Director of Center Programs a behaviorally trained professional to supervise those who design and implement appropriate treatment, training and programming for clients and sufficient psychologists to develop and implement all training programs and data collection and evaluation.

1. NVTC currently employs 5 psychologists and 6 qualified psychology technicians. NVTC will establish and advertise for one additional psychology position and fill that position by July 1, 1996.

2. By July 1, 1996, the overall ratio of psychology staff to clients will be 1:34. The psychologist assigned to the Special Behavior Unit will have a ratio

of 1:20 clients plus a small number of clients from Unit 1 with relatively few behavioral needs.

F. NVTC will employ sufficient nursing staff to provide adequate nursing services to appropriately monitor the clients' health and medical needs. NVTC currently has 23 Registered Nurse positions and 4 Licensed Practical Nurse positions representing a staffing of 14 nurses on A.M. shift, 8.5 on P.M. shift, and 4.5 on NOC shift. The on duty nurse to client ratio will continue to be at least 1:25 A.M. shift, 1:30 P.M. shift and 1:55 NOC shift.<sup>1</sup>

G. NVTC currently employs three physicians who serve as the primary care physicians for the clients. NVTC will maintain this level of staffing. A physician is on-site or on-call and available seven days a week, 24 hours a day. NVTC's current night call schedule is published monthly and includes home and beeper numbers. Two of NVTC's physicians cover one night per week and one weekend per month each including Friday, Saturday and Sunday nights. The Medical Director covers one night per week. A family practitioner covers one night per week. Another family practitioner covers two weekends per month. EMT and ER services are also available and located within five minutes from the Center. NVTC will maintain a night and on-call system, or a similar system, to meet the requirements of this plan.

H. NVTC will afford sufficient consultation with appropriate medical specialists including psychiatrists, neurologists, orthopedists and a physiatrist and otherwise provide services to clients as may be needed to provide adequate care and treatment. (See Attachment 7.)

1. NVTC will continue to contract for the on-site services of a psychiatrist 2 full days per week (at least 6 1/2 hours per day) plus a psychiatric fellow approximately one day per week.

2. In addition to off-site services, NVTC will continue to contract for the on-site services of a physiatrist at least quarterly, an orthopedist quarterly, and a neurologist 2 full days per month. (Full days may be reduced to partial days if and when patient needs allow.) NVTC will also continue periodic consultation with a geneticist for diagnostic purposes.

I. By July 1, 1995, NVTC will hire three (3) full time additional physical therapy positions with the goal of filling these positions by July 1, 1996. These positions include one licensed physical therapist and two physical therapist assistants, bringing the total physical therapy positions at NVTC to 3 registered physical therapists and

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<sup>1</sup>Nothing contained herein shall be construed to prevent NVTC in the exercise of its own discretion, from deploying a greater proportion of nursing staff than is required by this Plan.



3 licensed physical therapy assistants. This will bring the ratio of physical therapists as of July 1, 1996 to 1:34.

J. By July 1, 1995, NVTC will establish and advertise for one additional registered occupational therapist position and 3 certified occupational therapist assistant positions. NVTC's goal is to fill these positions by July 1, 1996. This will bring the total number of funded OT positions to 7. The ratio of occupational therapists to clients as of July 1, 1996 will be 1:29.

K. By July 1, 1995, NVTC will establish 1.5 additional dietitian positions bringing the total number of dietitian positions to 2.5. NVTC's goal is to fill these positions by July 1, 1996.

#### IV. STAFF TRAINING

All staff who provide services to NVTC clients are adequately trained to fully implement the requirements of this Plan and are thereafter provided with in-service training on a regular basis. The training will be competency-based and will include, but not be limited to: behavior management techniques; implementation of individualized treatment and training programs; emergency medical response, including recordkeeping for such procedures.

##### A. Pre-Service Training

1. All new employees of NVTC will continue to be required to attend a basic orientation program within the first 30 days of employment and successfully complete all components before the end of their probationary period. This orientation provides basic information in the following mandated subject areas: Personnel Policies, Orientation to NVTC, Abuse Policy, Human Rights Regulations, Safety and Security Procedures, Infection Control/AIDS, Normalization, Introduction to Mental Retardation, Seizures, First Aid, Body Mechanics and Lifting, and Sexual Harassment.

2. NVTC will continue to require NVTC direct care staff to successfully complete additional training as part of their orientation training, and a competency-based training program at their worksite. (Attachment 8). Coursework will concentrate on additional health/nursing information and emergency procedures, behavior management techniques, appropriate interactions and teaching techniques, specific clinical information and strategies necessary to be able to implement individual programs, and documentation and data collection. The orientation program will also include Active Treatment, Behavioral Documentation, Use of Mechanical Restraints, Adult CPR, Side Effects of Medications, and the Mandt System for Managing

People. (Attachment 9). Most of the orientation sessions in the clinical areas will continue to be competency-based (tests, return demonstrations, etc.). In addition, there is a final written exam. Staff who are unable to demonstrate competency are terminated from employment. In keeping with NVTC's goal to share resources with the community, the orientation program will continue to be offered to all of the local community agencies who frequently attend sessions and comment on the quality of the training their staff receive at NVTC.

3. Training in the Mandt System will continue to be a component of the staff development program and will focus on all interactions between people. The major emphasis of the program is on non-physical interventions. It stresses the need to interact appropriately at all times in an effort to prevent individuals from becoming upset. All direct care staff receive the two-day Intermediate Level of training in pre-service. An annual one-day recertification is also required.

4. All staff development programs will continue to emphasize several major themes which support the Mission Statement of the agency: appropriate staff to client interactions (treatment with dignity and respect), and the need to encourage and teach client independence. The importance of providing an environment which is supportive, protective, encouraging, reinforcing, and proactive is included throughout the entire orientation program.

5. NVTC has developed and will continue to use a competency-based training program for new employees which is utilized at the work site once the employee has successfully completed the orientation portion of the pre-service program. The Direct Care Competency Training Program (DCCTP) provides opportunities for new staff to demonstrate to their supervisors competence in all aspects of their job responsibilities. (Attachment 10). The DCCTP includes sections on Philosophy, Personal Care/Health/Hygiene, Active Treatment, Documentation, and Policy. Sections on Understanding Basic Behavior Intervention Programs and Program Implementation have been added to the Active Treatment portion of the original program. New employees continue to have six months (the remainder of their probationary period) to complete the program. Accompanying the DCCTP is a competency book of 50 task analyzed job duties in providing health related care, staff/client interactions, provide/maintain a safe living area, and how to implement program plans.

6. Compliance with the completion requirements for the Pre-service program and DCCTP will continue to be monitored by the Training Department. Notices are sent to supervisors monthly advising them of staff



2. In addition to Adult CPR, NVTC will continue to conduct emergency medical response drills. (Attachment 13). The purpose of these drills is to allow all staff involved the opportunity to practice responding to mock medical emergencies to better prepare them for a real situation. Nursing staff coordinate, monitor, and evaluate these drills and send documentation to the Training Department.

3. Compliance with mandated training requirements will be monitored by the Training Department. Quarterly summaries of compliance rates with mandated training requirements are sent to the supervisors.

4. NVTC's curriculum on Client Record System and Documentation has been developed and will continue to be included in the Annual Retraining Program. Target date for implementation was June 30, 1995.

5. Recognizing that the skills and knowledge necessary for direct care staff assigned to different work sites will vary depending upon the specific needs of the clients, program managers are in the process of working with the Training Department to determine additional training requirements for direct care staff assigned to each unit. Building 7 began this pilot in late 1994 and began implementing its plan in January 1995. (See Attachment 14 for Building 7 Plan). All residential buildings will have completed plans by September 30, 1995.

C. Physical Management Training

Training the Physical Management curriculum "Challenges in Physical Management", as described in Pre-service Training, Paragraph A.9 above, will begin for direct care and clinical staff by January 31, 1996. Staff assigned to Units 1, 3A, 3C, 3D, and 5A will participate in more intense in-services and client specific training at their work sites. These in-services will be provided quarterly at a minimum. Whenever an individual client program is developed or modified, all staff will be trained on these changes.

D. Individual Behavioral Programming Training

1. During pre-service, staff receive training on Behavior Modification, Teaching Techniques (Task Analysis, Prompting, Reinforcement, Error Correction), Crisis Management, Behavioral Documentation, and Use of Mechanical Restraints. This training is meant to be general in nature and provide staff with the "tools" to be able to implement individualized program plans. However, staff are not permitted to implement program plans until they have received additional training on the individual plans.

2. Once an employee completes the pre-service program, he or she begins working on the assigned work site. If clients on the unit have behavior programs, the new staff member is not allowed to implement them until he or she has been properly trained by the psychologist or psychology assistant. The psychology staff will monitor the training of each new staff member in all aspects of the program (including the specific target behavior, the objective, how to prevent the behavior from occurring, what to do when the targeted behavior is displayed, the adaptive and reinforcement components of the program, and data collection requirements). NVTC policy also requires that staff be re-trained on all behavior programs whenever there are changes to the program or every six months, whichever comes first. This training is documented and forwarded to the Training Department for inclusion in each employee's training record.

3. As new behavior support plans are written and summarized on new forms (Client Behavior Profiles), as described in Section II.C above, these will become a quick study guide and training tool for staff. Completion date is January 31, 1996.

4. To further develop the knowledge of staff regarding behavioral principles, all direct care staff will be required to complete the "Basic Behavioral Principles and their Applications to People with Developmental Disabilities" software package previously mentioned in the section on Pre-service Training. The completion date for this training for Units 5C, 6, 7C, 8A, and 8C is October 31, 1995, and for Units 1, 3A, 3C, 3D, 5A, and 7A is June 30, 1996.

E. Feeding/Mealtime Training

1. The Training Department has begun providing and will continue to provide in-services on Active Treatment focusing on the mealtime activity. This training stresses the importance of implementing individual goals and objectives from the IHP into the meal experience. Staff are quizzed on their knowledge of individual client programs, followed by discussion and demonstration of how these client needs can be integrated and implemented before, during, and after each mealtime. NVTC has completed training on Units 1, 3D, 5A, 5C, 6, and 7A. Units 3C and 7C are scheduled to be completed by February 1, 1996. 3A will be completed by March 1, 1996, 8A by April 1, 1996 and 8C by May 1, 1996. All active treatment training will be complete by May 1, 1996.

2. A concentrated interdisciplinary effort around several mealtime issues was begun in the Fall of 1994. The goal is to create a mealtime environment and experience which is more normalizing and more enriching, as well as

therapeutic in nature. This is accomplished by evaluating the physical environment of the dining areas, the time and resources allocated to mealtimes, and the knowledge of staff in mealtime programs and issues of active treatment. Clinical staff have established days and times to be in the dining areas to assist, model, and provide feedback to staff on mealtime techniques and program implementation. This will continue on an on-going basis. Monitoring is to be done by building supervisory staff. Specific outcome measures will be established by the clinical departments, in conjunction with the I.D. Team, for each specific unit by October 31, 1995.

3. As client programs are developed and modified, direct care staff will continue to be trained in these individual program plans by the appropriate clinical staff. Such reviews are documented and become part of the employee's training record. Clinical staff regularly and periodically review general information as well as client-specific information with the staff. This is documented and forwarded to the Training Department for inclusion in the employee's training record.

4. NVTC has purchased a tutorial software package on Active Treatment which will be included in the pre-service program. All direct care staff will complete the tutorial by July 1, 1996.

F. Continuing Education for Professional Staff

1. NVTC has established minimum continuing education requirements for its clinical staff. (Attachment 15). These were established for professional positions for which there are no state mandated or licensing continuing education requirements. These were established by the appropriate department heads and were based on standards from other states. Clinical staff who attend a training event which meets a continuing education requirement send documentation of this to the Training Department and it is entered into their training record. Summaries of training are provided to the supervisors and employees upon request. This continuing education process will be ongoing.

2. Records will be kept on compliance with required continuing education and reported back to supervisors and the Quality Management Committee on a quarterly basis. Reports will begin with training completed by December 31, 1995.

## **V. PHYSICAL THERAPY AND OCCUPATIONAL THERAPY MANAGEMENT**

NVTC will provide clients with adequate physical management, including appropriate physical therapy and occupational therapy programs. In addition to staffing outlined in Section III, J and K, NVTC shall take the following steps to accomplish this:

### **A. Physical Therapy**

1. By March 30, 1995, NVTC will design and provide new wheelchairs and seating systems to 32 residents. (Attachments 16 and 18).
2. By March 30, 1995, NVTC will design and fit 19 new seating systems into current wheelchairs.
3. By December 31, 1996, NVTC will upgrade and/or replace the remaining third of individual wheelchairs. Provision of wheelchairs and wheelchair modifications will be based upon a professional assessment of those most in need; all adaptive equipment will be individualized and there will be a continual adaptation of wheelchairs and other equipment as individual needs change. (Attachments 16 and 18).
4. By March 30, 1995, NVTC will develop and staff an on-site workshop dedicated to wheelchair and positioning equipment.
5. By March 30, 1995, NVTC will complete modifications to the water heating system for the Hubbard Tank to permit staff to conduct hydrotherapy during cold weather months.
6. By June 30, 1996, NVTC will reevaluate all clients with fixed contractures and reassess their potential for improvement with consultation from orthopedic and physiatric consultants.
7. By June 30, 1995, NVTC will establish 24-hour positioning schedules for all clients in need of positioning on Unit 1 and Building 3:
  - a. By March 30, 1995, NVTC will begin taking photographs of clients in various positions, with accompanying written descriptions of the benefits of placement in each position. These photographs will be assembled in unit-based books for daily use.
  - b. By April 30, 1995, NVTC will implement completed positioning programs in Unit 1.

c. By June 30, 1995, NVTC will implement completed positioning programs in Building 3.

8. By July 1, 1996, NVTC will establish and implement a staff training course for physical management of clients who demonstrate challenging mealtime and positioning needs.

9. By July 1, 1995, NVTC will select a physical management training program following review of several physical management training packages by the Training Department, Director of Occupational Therapy, Director of Physical Therapy and Director of Center Programs.

10. By July 1, 1996, physical management training will become part of pre-service orientation for all new staff and yearly re-training will also be required.

B. Occupational Therapy

1. A new Director of Occupational Therapy Services was hired on July 18, 1994. The Director will not serve as program manager for any other Building or Unit at NVTC.

2. By December 31, 1995, NVTC will be established as an internship site for students in occupational therapy professional training programs.

3. By July 1, 1996, NVTC will complete a pilot project involving sensory-motor integration training/treatment for four clients. Data will be collected and assessed. If data shows positive benefits for clients, the training/treatment program will be implemented with other clients whose need for such training/treatment has been identified by professional staff.

## VI. NUTRITIONAL MANAGEMENT AND FEEDING

NVTC will provide clients with adequate nourishment, identification of nutritional deficiencies and appropriate feeding programs and adaptive equipment for use at mealtimes. NVTC will take the following steps to accomplish this:

A. By April 1, 1995, NVTC developed and began pilot implementation of a Nutritional Risk Assessment Form.

1. Pilot testing, modification and refinement of the Nutritional Risk Assessment Form will be completed by December 31, 1995.



2. A Nutritional Risk Screening Assessment form has been completed for each resident determined by staff to have specialized nutritional and/or feeding needs, and such a form will be completed for each resident identified in the future with a specialized need. Training appropriate to the resident's needs, based upon nutritional risk assessment, will be conducted for all staff members having nutritional responsibility and/or feeding responsibilities with respect to the resident. It is understood that staff working with residents with the highest risk will be the first to receive the training.
- B. By July 1, 1995, NVTC will establish one and one-half additional dietitian positions. By July 1, 1996, NVTC shall have on staff two and one-half Registered Dietitians.
- C. By September 1, 1995, NVTC will have provided consultation to direct care and professional staff on Units 1 and Building 3 by a multi-disciplinary nutritional management team, including an occupational therapist, physical therapist, speech pathologist and dietitian. (Attachments 17 and 18).
- D. By December 31, 1995, NVTC will receive equipment designated as needed to implement modifications identified by nutritional assessments. Items will include one weighing scale, specialized calipers to assess nutritional status and measuring boards.
- E. By December 31, 1995, NVTC will purchase the adaptive equipment for use during meals which has been identified as needed by physical therapy and occupational therapy staff. (Attachments 16 and 18).
- F. By July 1, 1995, NVTC will receive 30 dining room chairs and accompanying tables for mealtime use on Building 3.
- G. By March 30, 1995, NVTC will install a dishwasher in the Building 3 dining room, so all adaptive equipment can be cleaned on-site.
- H. By March 30, 1995, NVTC will install an answering machine in Dietary the Services office to permit units to report, at all hours, adaptive feeding equipment needs.
- I. By July 1, 1996, NVTC will provide for diagrams and photographs of residents to be placed in the dining room next to each resident.

## VII. MEDICAL CARE

Residents will be provided with adequate medical care. In order to accomplish this, NVTC will:

### A. Quality Assurance

Implement a peer review mechanism for all disciplines involved in providing health services. The Quality Assurance Program for Health Services (Attachment 19) provides for systematic credentialing procedures, staff education, reviews of adverse events or outcomes by a Clinical Practice Review Committee, as well as for peer review for medical and nursing practitioners.

a. Medical peer review was initiated on November 4, 1994 and the process of this review will continue, with systemic refinements, as needed.

b. NVTC's medical director will serve on a committee which includes the Director of Resident Records in order to develop a system for monitoring and improving physician documentation in charts. This review and planning period will be completed by September 1, 1995.

### B. Medical Specialty Consultation

NVTC maintains a regular schedule of consultation with medical specialists. (See Attachment 7.) These include neurology, ENT, orthopedics, ophthalmology, psychiatry, physiatry, gastro-intestinal, podiatry, urology, cardiology, gynecology, dermatology and genetics. Recruitment for additional specialty medical consultants will continue, as needs are identified. Notes from these consultations will continue to be included in residents' records and a procedure for monitoring will be established by September 30, 1995. See also Section IX. Recordkeeping Section.

### C. Medical Management of Residents with Epilepsy

1. An interdisciplinary epilepsy committee developed and implemented a new charting system for the epilepsy clinic. (See Attachment 20.) Information from this charting will be incorporated into the new resident record system by March 30, 1995. A procedure for monitoring compliance with the requirement of inclusion of charting information into resident records will be established by September 30, 1995.

2. By December 31, 1995, semi-annual audits of antiepileptic drug prescribing practices will be conducted by the Pharmacy and Therapeutics Committee, which performs the functions of a drug utilization review committee. Information from these audits will be considered by the interdisciplinary epilepsy committee and will be submitted to the Quality Management Director. Appropriate monitoring and follow-up will occur, as necessary.

a. NVTC will emphasize use of monotherapy and deemphasize use of barbiturates and phenytoin.

b. The Pharmacy and Therapeutics Committee will continue to monitor the consistency of charting and medication adjustment/change in individuals with epilepsy and seizures.

c. One index of improved quality of life for clients receiving epileptic drugs has been identified as reduced use of helmets for clients with epilepsy. Monitoring of frequency of helmet use has shown a reduction of 38% in the use of helmets from 45 in 1989 to 28 in February, 1995. NVTC will rely upon controlled medication trials and ongoing monitoring of improvement to determine further appropriate reduction of helmet use. (Attachment 4).

3. Individual treatment protocols for status epilepticus will be implemented by September 30, 1995.

4. A videotape and brochures for staff and family education will be completed by the interdisciplinary epilepsy committee by October 30, 1995.

5. Beginning June 30, 1995, the interdisciplinary epilepsy committee will review epilepsy-related injuries, infirmary and hospital admissions on a quarterly basis and report its analysis of this data to the Quality Management Director.

6. Guidelines were developed in September, 1994 for nursing care of clients with seizures and for first aid by residential staff. Guidelines for residential staff were posted in October, 1994. (Attachment 21).

Compliance with these guidelines will be assessed through routine audits of individual charts by a procedure to be established by September 30, 1995.

D. Emergency Responsiveness

1. Monthly emergency responsiveness drills, involving nursing, security and residential staff, were begun in May, 1994. (Attachment 22). The nurse manager will monitor the monthly drill reports and forward the analysis of these results and recommendations to the Quality Management Director, beginning on September 30, 1995.
2. Documentation of response times of EMS personnel to 911 calls from NVTC and of NVTC nurses to on-campus emergencies was begun in May 1994. (Attachment 23). The nurse manager will monitor the response times of EMS and nursing staff members and will report the results of this monitoring to the Quality Management Director, beginning on June 30, 1995.
3. Emergency notification procedures were posted on residential units in October, 1994. (Attachments 24 and 25). Compliance with these procedures will be monitored by the nurse manager through chart audits, and compliance rates gathered from this monitoring will be submitted to the Quality Management Director, beginning on September 30, 1995.

VIII. MEDICATION MANAGEMENT

Beginning December 1, 1995, a semi-annual audit of psychotropic medication prescribing practices will be conducted by the Pharmacy and Therapeutics Committee, which performs the function of a drug utilization review committee, with the results of these audits transmitted to the Quality Management Director. Appropriate monitoring and follow-up will occur, as necessary.

1. Since mid-1989, NVTC's use of antipsychotic (neuroleptic) drugs has been reduced by 33%. As of December 31, 1994, 26 clients were receiving this class of drugs, in comparison with 39 residents five years previously. (Attachment 26).
2. The Dyskinesia Identification System: Condensed User Scale (DISCUS) was adopted for monitoring tardive dyskinesia and other side-effects of clients on psychotropic medications in August, 1993. (Attachment 27). Information from this instrument will be reviewed quarterly by the Pharmacy and Therapeutics Committee beginning in June, 1995. Information from this review will be submitted to the Quality Management Director.
3. The consulting psychiatrist and Medical Director will continue to serve as members of the Behavioral Management Committee.

4. NVTC will follow its policies and procedures regarding the use of psychotropic medication, e.g. NVTC Instruction 5302 on Psychotropic Medication (Attachment 28), Medical Plan for Psychotropic Drug Use, consent forms (Attachment 29) and Health Services Policy and Procedures (Attachment 30).

## **IX. RECORDKEEPING**

NVTC will develop and implement a system of records for each client, developed and maintained under the supervision of a qualified professional whose primary responsibility will be to properly maintain client records. Each record will be readily available to all staff and will contain current information with respect to the client's care, medical treatment, and training, and will be organized so as to enable those using it to render professional judgments in providing care, medical treatment, and training to the client. NVTC will require staff to utilize such records in making care, medical treatment, and training decisions.

NVTC has approved for implementation a new Client Records System, the "Source Oriented Medical Record with Integrated Progress Notes". Revision of the record system has been divided into five phases: I. Recruitment; II. Research and Development; III. Training; IV. Implementation, and V. Quality Management. Timetables for each section are outlined in Attachment 31. Phases I and II have been completed. NVTC's plan provides for:

- A. Recruitment of a qualified Health Information Manager. A new Director of Resident Records, was hired on August 22, 1994. This position will oversee implementation of the new client records system in 1995.
- B. Development of a new Client Records System: Following three months of reviewing the current records management system, site visits to other facilities, solicitation of input from facility staff and researching recordkeeping techniques, a new client record system was proposed. In November and December 1994, the proposal was presented to Resident Record Committee members, clinical and residential staff and Senior Staff. On December 20, 1994, the Source Oriented Medical Record with Integrated Progress notes was approved for use beginning June 30, 1995. Attachment 32 summarizes the system which has been accepted.
- C. The most significant change represented by the new client record system is the integrated progress note, "Interdisciplinary Note", section. In this centralized section, professional disciplines will be charting information pertaining to the client. (Attachment 33). Specific documentation instruction to staff include guidelines for all those making entries into the centralized progress notes and contain "prompts" for

entry of indicators such as "OT Monthly Notes" as a title (qualifier) for easy identification and review.

D. Training: Beginning in March, 1995, Medical Records staff, in conjunction with the Training Department, will begin training in the new records system. Small departmental groups have been targeted for individualized training. Training will require each staff member to convert an existing client record to the format created by the new records system. Instructional guides will be provided for each staff member. Training for all residential and clinical staff will be completed by June 30, 1995. Follow-up sessions will be scheduled, as needed.

E. Implementation: Since records will be revised during training sessions, facility-wide implementation of the new records system will be completed by June 30, 1995.

F. Quality Management: By June 30, 1995, the current Resident Records Quality Management Plan will be amended to include quality mechanisms for monitoring implementation of the new system. Amendments will include provisions for:

1. Establishing a random sampling of records from each unit for compliance review by the Medical Record department staff and members of the Resident Record Committee.
2. Completion of initial reviews for all units will be completed by September 30, 1995 and a schedule for ongoing reviews of compliance with requirements of the new system.
3. Establishing criteria for monitoring which include, at a minimum:
  - a. correct chart identification on each CRS;
  - b. correct record filing order;
  - c. correct chronological date order for documents;
  - d. entries made to the integrated progress notes which are prefaced with qualifiers stating the discipline documenting the note; and
  - e. correct use of double-sided progress notes.
4. Reporting results of each random sampling on a quarterly basis to the Quality Management Committee and the facility Resident Records Committee.

## **X. QUALITY MANAGEMENT PLAN**

NVTC will develop and annually update a Quality Management Plan that will monitor, document and evaluate implementation of the activities identified in this Plan. Attachment 34 is NVTC's Quality Management Plan for FY 94-95.

## **XI. COMMUNITY PLACEMENT**

A. NVTC will reduce the number of current clients at NVTC in accordance with the NVTC Community Integration Initiative developed in 1991 with the primary objective of reducing current (i.e. 1991) resident census from 270 to 200 persons. This will be accomplished by securing appropriate community-based placements for those clients it determines in accordance with professional judgment to be eligible and appropriate for such placement, subject to the procedures described in ¶ C below. Full implementation of the Community Initiative will occur by July 1, 1996. Attached is a description of the Community Initiative outlining timelines employed, schedule for continued downsizing, and the process that has been used and will be used to meet its objectives. (Attachment 35).

B. NVTC will annually assess the needs of all remaining residents at NVTC as follows:

1. The treatment team will annually assess in accordance with the exercise of professional judgment the needs of all residents at NVTC at the time of the development of the annual IHP to render an evaluation with respect to the appropriateness of continued placement at NVTC. Such assessments will occur more frequently if a change in the needs of the resident so indicates.

2. Subject to the provisions of ¶ 4, if all appropriate professionals employed by or under contract with the Commonwealth to assess a resident, including but not necessarily limited to the assigned interdisciplinary team, determine that NVTC is not an appropriate setting for a resident and that a resident would be more appropriately served in a community setting, appropriate professionals will, within a reasonable time thereafter, develop such plan as may be appropriate and feasible to provide necessary services to the resident in a community setting, and will place the resident in accordance with the plan within a reasonable time after such plan has been developed and can be feasibly implemented. Sound, prudent fiscal considerations, and generally accepted business practices may be used by NVTC in determining whether a plan to place a resident in the community is feasible and, if so, when such plan can be feasibly implemented. In no event will NVTC have an obligation under the Plan to discharge or transfer a resident before a

community setting that would more appropriately serve the resident has been identified and there is such a setting available.

3. In all decisions with respect to individual residents, the views and opinions of the individual resident, parent(s), guardian(s), other appropriate surrogate decision-maker(s) and professionals will be appropriately considered by NVTC. When it is determined that NVTC is not an appropriate setting for a resident, NVTC will ensure that the views and opinions of the individual resident, parent(s), guardian(s), appropriate surrogate decision-maker(s) and professionals will be considered when developing and implementing an appropriate and feasible discharge plan.

4. Where the consent of parent(s), guardian(s), or other surrogate decision-maker(s) is withheld regarding discharge or placement, in disagreement with the judgment of professionals employed by or under contract with the Commonwealth, NVTC will make its discharge and transfer decisions after consultation with the individual resident, parent(s), guardian(s) or other appropriate surrogate decision-maker(s) and, after such consultation, will engage in a good faith effort to reach a consensus as to what decision about discharge and/or placement is in the best interests of the individual NVTC resident in exercise of its discretion on a case-by-case basis. The parent(s), guardian(s) or other surrogate decision-maker(s) may present the opinion of a qualified professional(s) for consideration by NVTC with respect to discharge and/or placement decisions. If the NVTC decision is ultimately to retain the resident, NVTC will continue to involve the parent(s), guardian(s) or other surrogate decision-maker(s) in the treatment and discharge planning process and continue to make them aware of available opportunities in the community for the care of the resident through parental educational opportunities conducted by community providers.



**NORTHERN VIRGINIA TRAINING CENTER**

**CASE NO. 96-283-A**



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**Commonwealth of Virginia**

**Department of Mental Health, Mental Retardation  
and Substance Abuse Services**

**NORTHERN VIRGINIA TRAINING CENTER  
PLAN**

**As revised through**

**June 27, 1996**

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**Department of Mental Health, Mental Retardation  
and Substance Abuse Services**

**NORTHERN VIRGINIA TRAINING CENTER  
PLAN**

March 13, 1995

**As revised through  
June 27, 1996**

This Plan has been prepared by the Northern Virginia Training Center (NVTC) in response to concerns raised by the United States Department of Justice (DOJ) in connection with its investigation of NVTC under the Civil Rights of Institutionalized Persons Act (CRIPA), and following its original tour of NVTC. The Plan is incorporated by reference into the Settlement Agreement executed by the Commonwealth of Virginia and the United States of America, and is subject to the terms thereof.

## **I. DEVELOPMENT AND IMPLEMENTATION OF TRAINING PROGRAMS UTILIZING POSITIVE TRAINING TECHNIQUES**

NVTC provides training programs developed by qualified professionals utilizing positive training techniques designed to afford skill development, personal safety and reasonable use of restraints and prevent regression of residents. In order to accomplish these programs, NVTC will:

A. By July 1, 1996, NVTC will professionally evaluate and/or re-evaluate each resident using multi-disciplinary evaluations, as needed. Each individual will receive a psychological review or comprehensive evaluation as part of the development of his or her annual habilitation plan. The annual review will consist of a review of previous evaluations to determine continued validity, review of the client's chart, observations of the client, report of behavioral treatment, behavioral data, comparison of the current service period with the previous one to determine relevant changes, and statements concerning a person's needs and recommendations for treatment. If a significant change is noted in the individual, the ID Team will request additional information and the psychologist will provide the necessary evaluations. Full psychological evaluations will be completed for clients every three (3) years, or more frequently if conditions warrant. A full psychological evaluation will include a concise description of the resident, an appropriate assessment of intellectual/cognitive functioning and adaptive behavior, assessment of mental health problems (if appropriate), review of previous evaluations and comparison of the current test results with previous results to determine trend, review of behavioral observations, review of behavioral procedures and data, the resident's strengths, needs and the psychologist's recommendations. These evaluations will focus on the assessment of functional skills and interests through ecological and person-centered assessment procedures. Each assessment will coincide with each client's annual Individual Habilitation Plan (IHP) schedule.

1. By August 1, 1995, all current and future admissions to the Special Behavior Unit will receive a functional assessment. (Attachment 1). A widely used functional assessment tool developed by Robert Horner and colleagues, called Functional Analysis of Problem Behavior, will be used as a primary assessment guide. Other assessment tools, such as the Aberrant Behavior Checklist, the Psychopathology Instrument for Mentally Retarded Adults, the Reiss Screen, the Autism Behavior Checklist, and ecological and analog assessment strategies will also be employed as needed.

2. By March 1, 1996, all clients receiving psychotropic medication and/or restrictive behavior support plans will receive a functional assessment as part of their individualized behavioral support plan. A functional analysis will be conducted thereafter as needed, at least on an annual basis.

3. The Director of Center Programs is developing a training curriculum for the psychology staff with specific training in functional and ecological assessment and the use of this information in the development of positive behavior support plans. A major focus for all persons will be on teaching more appropriate skills to replace challenging behaviors. The first training class is planned for August 1, 1995 and training will be completed by March 1, 1996.

4. Every client for whom a behavioral need is identified or who has a behavioral program will receive a formal functional analysis as part of the development of a behavioral support plan by July 1, 1996. In developing and assessing behavior plans, priority will be given to those individuals whose behavior places them at greatest risk. NVTC will establish priority for program development for those residents who exhibit Pica, self-injurious behavior or other behavior that is dangerous to self, others, or property and for those residents for whom relatively high usage of time-out and/or restraint is shown by objective and reliable data. Such individuals will receive functional analyses which are focused on assessing the specific problems demonstrated by the individual. Behavioral plans will be based upon objective and reliable data and interventions documented in those plans will be based upon data collected. When appropriate, current literature will be considered in developing behavior plans.

B. NVTC will continue to develop and implement a professionally based training program for each client and provide each client with an adequate number of hours of training pursuant to applicable standards utilizing positive approaches to enable the client to develop behaviors which will afford safety, freedom from undue restraint and other restraints on the individual's movement within and about the facility and to prevent regression or deterioration of skills. By July 1, 1996, each training program will contain at a minimum:

1. Training objectives developed by an appropriately constituted interdisciplinary team and based upon assessments and evaluations required by paragraph 1 above for those clients who have been identified as needing mental health services, which comport with applicable standards;

2. Specific instructional methods to be utilized by those with responsibility for implementing the program; such methods will emphasize positive approaches and positive behavioral interventions which promote functional skill development and socially acceptable behaviors for the individual client;

3. A specific training schedule to be followed; the number of hours of training to be provided will be sufficient to permit the client for whom the

program has been developed to have a reasonable opportunity to reach the identified behavioral objective(s) of a training program; no schedule will provide for fewer than 40 hours of structured training or activities each week, unless medically contraindicated;

4. Procedures utilized for data collection will be sufficient to permit a qualified professional to evaluate the effectiveness of the training program or any part thereof and to monitor the implementation of the plan and ensure its modification, as necessary. Documentation forms for tracking adaptive and maladaptive behaviors have been standardized. A computerized data tracking system is being used to provide on-going functional assessment of behavior plans. Graphical representations of the data are and will continue to be presented to the Behavior Management Committee (BMC) and Local Human Rights Committee (LHRC) and are used for clinical presentations; and

5. Identification of the persons responsible for the consistent implementation of the program.

C. NVTC will consistently implement the training programs required in Paragraph B. above for all clients by July 1, 1996, and thereafter within fifteen (15) days of the development of the behavior plan by the ID team and full approval by the Behavior Management Committee (BMC), Local Human Rights Committee (LHRC) and parent/guardian. Notwithstanding this time frame, priority in the development and implementation of training programs will be given to any client exhibiting self-injurious, aggressive or pica behaviors. Any such client will have a professionally developed and consistently implemented training program within sixty (60) days of identification of the problem.

D. In order to afford consistent implementation of training programs, NVTC provides and will continue to provide adequate competency-based training for all staff responsible for implementing the programs specified in Paragraph B above. Staff training will focus on how to implement the programs and collect appropriate data. NVTC will conduct regular periodic follow-up evaluations of staff competency in implementing programs and provide additional training, as necessary.

1. By June 1, 1995, center-wide Psychology Behavioral Treatment Books will be available to all psychology staff, advocate, duty officers and roving team leaders. Also by June 30, 1995, Unit-specific Behavioral Treatment Books will be accessible to all unit staff as a reference for behavioral support plans.

2. Greater emphasis upon the preventive and positive procedures of the "Mandt" Training System have been included in staff orientation and during staff training of individualized behavior support plans. The entire staff

orientation training package for behavior management was reviewed in January 1995 and plans and timelines for a revised training package based upon preventive and positive behavioral support program philosophies and procedures have been established. Implementation of the revised training package is set for August 1, 1995.

E. NVTC has implemented and will fully maintain systems by March 1, 1996 for: (1) observing clients' behavior to determine the effectiveness of the programs and recording those observations; (2) verifying the reliability of the recorded data; and (3) ensuring that a qualified professional reviews and appropriately modifies any client's training program when the professional determines that the resident has exhibited no measurable progress for a significant period of time.

1. Unit-based clinical meetings will continue to occur semi-monthly to monitor clinical issues and address changing client needs. In the Special Behavior Unit (SBU), these meetings will occur weekly.

2. Unit-based psychotropic medication/behavior plan reviews will continue to occur weekly on the SBU and on all other units at least monthly. This interdisciplinary data-based review is attended by the psychiatrist, physician, psychologist, psychological assistant, nurse, direct care staff, program manager or team leader, and Qualified Mental Retardation Professional (QMRP). Vocational staff, parents and other pertinent professional disciplines may also attend.

3. Psychology staff will perform weekly reliability checks of treatment plans using direct observation of client behavior and implementation of behavior support plans by direct care staff. Documentation of behavior support plans will also be checked for reliability on a weekly basis by comparing direct care staff and client observations with log entries, behavior tracking forms, and entries in the client record by March 1, 1996.

4. QMRP's will continue to provide program monitoring at least quarterly as part of the Individualized Habilitation Plan (IHP) review system.

5. Active treatment will continue to be formally monitored using a system designed by Dr. Brian Iwata. Designated and trained staff will record observations at least twice a week for every unit. (Attachment 2). In January 1995, a data system was established in which active treatment information from this form will be used to make management decisions. The Risk Manager will enter the raw data and monthly reports will be generated for review by management staff. Active treatment and other measures will be integrated into a program monitoring plan to be submitted to the Quality Management Committee by August 1, 1995. The results of these measures



will be compiled and distributed quarterly to all clinical and unit departments and to the Quality Management Committee.

F. NVTC will develop by January 1, 1996, a system to regularly train all direct care staff in collecting and maintaining the behavioral data necessary to assess the effectiveness of any behavior program. Staff will be fully trained by July 1, 1996. NVTC will keep written records to document such training.

G. An interdisciplinary team will evaluate the efficacy of the training programs for each client with self-injurious, aggressive or pica behavior on a monthly basis and the efficacy of the training programs for all other clients on at least a quarterly basis. The team will base its review of the efficacy of the training programs on the data collected as well as the occurrence of incidents (events) and the use of restraints. If the team recommends the need to revise the training program, it will be reviewed and revised, if appropriate, by a psychologist within thirty (30) days.

H. The Behavior Management Committee, including the Director of Medical Services and, as appropriate, a psychiatrist, will review behavior plans and supporting documentation relating to each resident who: (1) exhibits self-injurious or aggressive behavior, or (2) is subject to restrictive programming, frequent behavior control procedures, or receives behavior modifying medication, to ascertain whether: (i) there are sufficient behavioral data recorded, (ii) such data have been assessed for reliability, and (iii) the continuation of the current training or treatment program is justified, or the program, including medication, should be modified. Where inadequate or unreliable data are found, or the continuation of the training or treatment program is otherwise not justified, the matter will be referred to the appropriate interdisciplinary team which shall, within 30 days of the referral, modify the existing program in accordance with the judgment of qualified professionals, including the primary care physician, psychologist and psychiatrist, as appropriate. When in the judgment of qualified NVTC professionals, data indicates that individual programs as implemented have been ineffective and outside independent consultation is necessary to assist in devising an appropriate revision to the program, NVTC will obtain such consultation.

## **II. USE OF PHYSICAL RESTRAINT AND TIME OUT**

NVTC has developed and will continue to implement policies and procedures to ensure that time-out and physical restraints are administered only pursuant to the judgment of a qualified professional and are not used as punishment, in lieu of training programs, or for the convenience of staff. These policies and procedures are contained in NVTC Instruction 5300 (Restrictive Procedures) and NVTC Instruction 5301 (Use of Protective Devices) and the Psychology Department's Behavior Therapy Procedures: Philosophy of

Use, Definition and Staff Responsibilities. (Attachments 3, 4, and 5). These policies and procedures will:

- A. Protect clients from unreasonable risks to their personal safety from both the conduct of staff and other clients, and from unreasonable use of bodily restraints.
- B. Provide for the use of bodily restraint and time-out only in conjunction with a written treatment and/or training program, except in emergency circumstances. An "emergency" is defined as "a situation in which a qualified professional deems a behavior to be likely to cause harm to the client or others or to property unless the proposed intervention is immediately initiated." For each emergency use of bodily restraint or time-out, the decision to use the bodily restraint or time-out must be made by a qualified professional after considering a hierarchy of less restrictive interventions. Each emergency use of bodily restraint or time-out will be described and recorded in the client's record including the identity of the professional making the decision and the justification for the decision. A client who has been placed in time-out or bodily restraints in emergency circumstances three times in the previous year will be assessed and a written treatment and/or training program developed, if necessary, within two weeks of the third incident, except in medical contingencies where the restraint is prescribed by a physician for short term use while the condition is being treated. A standardized Crisis Management Documentation Form has been used since January 1994 to track emergencies and will continue to be used.
- C. Require that, in every behavior program that utilizes bodily restraint or time-out, specification of:
  - 1. the behavior to be eliminated and the specific behavior, clearly and objectively defined, which triggers the use of the restraint or time-out;
  - 2. behaviors to be taught to the client to replace the behavior that initiates the use of the restraint or time-out and other programs to reduce or eliminate the use of such restraint or time-out;
  - 3. the restriction, i.e. type of restraint or time-out authorized and, where applicable, the duration of the restriction;
  - 4. the professional responsible for the program and the direct care staff authorized to implement the program;
  - 5. the frequency and manner in which behavioral data are to be recorded by direct care staff.

In order to accomplish the above, NVTC has revised the format of all behavior support plans (BSPs). A major emphasis is placed on functional analysis-based

treatment plans which rely upon individualized preventive and proactive behavioral procedures to address challenging behaviors. (See Attachment 6 for a sample of this new format.) A short summary of each BSP is also written to be used as a quick, easy reference for staff. All behavior plans and short summaries will be rewritten into this new format corresponding with the client's annual staffing. All BSPs will be written into the new format by January 31, 1996.

D. Require that beginning January 1, 1996, any treatment and/or training program utilizing bodily restraint or time-out will be reviewed before implementation and at least every three (3) months thereafter by the Behavior Management Committee (BMC) as well as by the Local Human Rights Committee prior to implementation of the program; provided, however, that under emergency conditions, the Chairman of the BMC may approve a program not to exceed 30 days.

E. Prohibit the use of bodily restraint or time-out except in: (a) those situations where there is written evidence in the client's record that other, less restrictive techniques have been considered and/or systematically tried and consistently implemented as part of a professionally designed training program and accurate, objective data have demonstrated such techniques to be ineffective and (b) emergency situations in which there is a risk of harm to self or others. Each time a device is used in an emergency situation or as a protective device, the client record must document that the decision to so use the device was made by a qualified professional; it must identify the professional making the decision, and it must document the justification for such use. Any use of restraint will be the least restrictive form of restraint after consideration of a hierarchy of less restrictive interventions. The use of papoose boards as a form of behavioral restraint was eliminated as of January 18, 1992 and will not be re-implemented. There are and will be no standing medical orders for PRN psychotropic medications.

F. Require that appropriate psychology staff will review monthly each use of bodily restraints or time-out occurring in the previous 30 days to ascertain whether each use was pursuant to the exercise of professional judgment or the behavior program of the resident subject to the use. The results of these monthly reviews, including the conclusions of the psychology staff, will be reported to the BMC every three (3) months, which will review whether a particular client needs a behavior program or whether an existing program should be modified. The BMC may initiate more frequent reviews when indicated. Restrictive measures will be continued in clients' programs only if reliable data supports the necessity of their continued use. The BMC will record these recommendations and transmit them to appropriate staff, as well as NVTC management, who will be responsible for ensuring that any new programs or revised programs are developed and implemented within 30 days.

### III. STAFFING REQUIREMENTS

NVTC will hire, deploy, and provide ongoing training to a sufficient number of competent and qualified direct care and professional staff to provide its clients with adequate care, treatment, and training programs.

A. A sufficient number of qualified staff, including physicians, psychologists, registered nurses, licensed practical nurses, registered physical therapists, licensed physical therapy assistants, occupational therapists, speech therapists, dietitians and direct care workers will be available. NVTC will demonstrate continuing efforts to achieve any additions to staff that are necessary for this purpose by January 1, 1996 and will achieve such staffing by July 1, 1996.

B. NVTC will maintain adequate direct care staffing levels while implementing its census reduction plan referenced in Section XI.A. below. NVTC currently meets an on duty direct care ratio of 1:4 on the a.m. shift, 1:5 on the p.m. shift and 1:9 at night. When the client census reaches 200 on July 1, 1996, NVTC will have and maintain a campus-wide staffing ratio of 1:4, 1:4, 1:8 and will continue to deploy staff based on the exercise of professional judgment to provide for the training and safety needs of all clients. NVTC will continue to provide 1:1 staffing for individuals whom qualified professionals at the facility have determined are in need of 1:1 staffing.

C. Direct care staff will not be routinely used to perform such support functions as housekeeping, laundry, other than client personal clothing, maintenance and meal preparation, etc. This requirement does not preclude direct care workers from training residents in these functions pursuant to a written training program developed in accordance with established procedures.

D. NVTC will employ sufficient senior clinical staff to afford adequate clinical supervision, case consultation, education and training of staff and to afford the provision of adequate services to clients.

E. NVTC will continue to employ as Director of Center Programs a behaviorally trained professional to supervise those who design and implement appropriate treatment, training and programming for clients and sufficient psychologists to develop and implement all training programs and data collection and evaluation.

1. NVTC currently employs 5 psychologists and 6 qualified psychology technicians. NVTC will establish and advertise for one additional psychology position and fill that position by July 1, 1996.

2. By July 1, 1996, the overall ratio of psychology staff to clients will be 1:34. The psychologist assigned to the Special Behavior Unit will have a ratio

of 1:20 clients plus a small number of clients from Unit 1 with relatively few behavioral needs.

F. NVTC will employ sufficient nursing staff to provide adequate nursing services to appropriately monitor the clients' health and medical needs. NVTC currently has 23 Registered Nurse positions and 4 Licensed Practical Nurse positions representing a staffing of 14 nurses on A.M. shift, 8.5 on P.M. shift, and 4.5 on NOC shift. The on duty nurse to client ratio will continue to be at least 1:25 A.M. shift, 1:30 P.M. shift and 1:55 NOC shift.<sup>1</sup>

G. NVTC currently employs three physicians who serve as the primary care physicians for the clients. NVTC will maintain this level of staffing. A physician is on-site or on-call and available seven days a week, 24 hours a day. NVTC's current night call schedule is published monthly and includes home and beeper numbers. Two of NVTC's physicians cover one night per week and one weekend per month each including Friday, Saturday and Sunday nights. The Medical Director covers one night per week. A family practitioner covers one night per week. Another family practitioner covers two weekends per month. EMT and ER services are also available and located within five minutes from the Center. NVTC will maintain a night and on-call system, or a similar system, to meet the requirements of this plan.

H. NVTC will afford sufficient consultation with appropriate medical specialists including psychiatrists, neurologists, orthopedists and a physiatrist and otherwise provide services to clients as may be needed to provide adequate care and treatment. (See Attachment 7.)

1. NVTC will continue to contract for the on-site services of a psychiatrist 2 full days per week (at least 6 1/2 hours per day) plus a psychiatric fellow approximately one day per week.

2. In addition to off-site services, NVTC will continue to contract for the on-site services of a physiatrist at least quarterly, an orthopedist quarterly, and a neurologist 2 full days per month. (Full days may be reduced to partial days if and when patient needs allow.) NVTC will also continue periodic consultation with a geneticist for diagnostic purposes.

I. By July 1, 1995, NVTC will hire three (3) full time additional physical therapy positions with the goal of filling these positions by July 1, 1996. These positions include one licensed physical therapist and two physical therapist assistants, bringing the total physical therapy positions at NVTC to 3 registered physical therapists and

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<sup>1</sup>Nothing contained herein shall be construed to prevent NVTC in the exercise of its own discretion, from deploying a greater proportion of nursing staff than is required by this Plan.

3 licensed physical therapy assistants. This will bring the ratio of physical therapists as of July 1, 1996 to 1:34.

J. By July 1, 1995, NVTC will establish and advertise for one additional registered occupational therapist position and 3 certified occupational therapist assistant positions. NVTC's goal is to fill these positions by July 1, 1996. This will bring the total number of funded OT positions to 7. The ratio of occupational therapists to clients as of July 1, 1996 will be 1:29.

K. By July 1, 1995, NVTC will establish 1.5 additional dietitian positions bringing the total number of dietitian positions to 2.5. NVTC's goal is to fill these positions by July 1, 1996.

#### **IV. STAFF TRAINING**

All staff who provide services to NVTC clients are adequately trained to fully implement the requirements of this Plan and are thereafter provided with in-service training on a regular basis. The training will be competency-based and will include, but not be limited to: behavior management techniques; implementation of individualized treatment and training programs; emergency medical response, including recordkeeping for such procedures.

##### **A. Pre-Service Training**

1. All new employees of NVTC will continue to be required to attend a basic orientation program within the first 30 days of employment and successfully complete all components before the end of their probationary period. This orientation provides basic information in the following mandated subject areas: Personnel Policies, Orientation to NVTC, Abuse Policy, Human Rights Regulations, Safety and Security Procedures, Infection Control/AIDS, Normalization, Introduction to Mental Retardation, Seizures, First Aid, Body Mechanics and Lifting, and Sexual Harassment.

2. NVTC will continue to require NVTC direct care staff to successfully complete additional training as part of their orientation training, and a competency-based training program at their worksite. (Attachment 8). Coursework will concentrate on additional health/nursing information and emergency procedures, behavior management techniques, appropriate interactions and teaching techniques, specific clinical information and strategies necessary to be able to implement individual programs, and documentation and data collection. The orientation program will also include Active Treatment, Behavioral Documentation, Use of Mechanical Restraints, Adult CPR, Side Effects of Medications, and the Mandt System for Managing

People. (Attachment 9). Most of the orientation sessions in the clinical areas will continue to be competency-based (tests, return demonstrations, etc.). In addition, there is a final written exam. Staff who are unable to demonstrate competency are terminated from employment. In keeping with NVTC's goal to share resources with the community, the orientation program will continue to be offered to all of the local community agencies who frequently attend sessions and comment on the quality of the training their staff receive at NVTC.

3. Training in the Mandt System will continue to be a component of the staff development program and will focus on all interactions between people. The major emphasis of the program is on non-physical interventions. It stresses the need to interact appropriately at all times in an effort to prevent individuals from becoming upset. All direct care staff receive the two-day Intermediate Level of training in pre-service. An annual one-day recertification is also required.

4. All staff development programs will continue to emphasize several major themes which support the Mission Statement of the agency: appropriate staff to client interactions (treatment with dignity and respect), and the need to encourage and teach client independence. The importance of providing an environment which is supportive, protective, encouraging, reinforcing, and proactive is included throughout the entire orientation program.

5. NVTC has developed and will continue to use a competency-based training program for new employees which is utilized at the work site once the employee has successfully completed the orientation portion of the pre-service program. The Direct Care Competency Training Program (DCCTP) provides opportunities for new staff to demonstrate to their supervisors competence in all aspects of their job responsibilities. (Attachment 10). The DCCTP includes sections on Philosophy, Personal Care/Health/Hygiene, Active Treatment, Documentation, and Policy. Sections on Understanding Basic Behavior Intervention Programs and Program Implementation have been added to the Active Treatment portion of the original program. New employees continue to have six months (the remainder of their probationary period) to complete the program. Accompanying the DCCTP is a competency book of 50 task analyzed job duties in providing health related care, staff/client interactions, provide/maintain a safe living area, and how to implement program plans.

6. Compliance with the completion requirements for the Pre-service program and DCCTP will continue to be monitored by the Training Department. Notices are sent to supervisors monthly advising them of staff

needing to attend specific classes. A quarterly compliance report is also sent to supervisors. (See Attachment 11 for sample of report.)

7. Beginning April 30, 1995, NVTC will include in the pre-service curriculum two software packages from Softpath Habilitation which teach (1) Active Treatment, and (2) Behavioral Principles and their Applications to People with Developmental Disabilities. The Active Treatment program is an automated interactive tutorial that teaches the basics of interacting with people with disabilities to ensure their greater independence. The focus of the Behavioral program is to teach direct care residential and workshop staff basic behavioral principles and their applications to people with developmental disabilities. The principles are taught in the context of common life experiences. Applications are taught in the context of working with people who have developmental disabilities. Each program is student-paced and is competency-based. These are intended to supplement classroom sessions, not to replace them.

8. The Behavior Modification curriculum will be implemented by August 1, 1995. The new curriculum will not rely on lecture format solely, but will incorporate experiential learning opportunities. Content will include traditional behavior modification and behavior management information, but concentrate on preventive and positive behavior support strategies, functional assessment, and person-centered planning.

9. NVTC has obtained the "Challenges in Physical Management" curriculum developed by the Oklahoma Department of Human Services. This is a 2-day comprehensive training program. The program is divided into 4 sections: Body Mechanics, Physical Assistance Techniques and Transfers, Positioning, and Putting It All Together. NVTC is also reviewing a program from Texas which provides additional areas of training. A qualified professional will deliver the training. When adequate professional staff are available, this curriculum will be included in the pre-service program for all direct care staff. NVTC will use its best efforts to implement this training program by January 31, 1996.

B. Other Mandated Training

1. NVTC will continue to require the staff to receive refresher training in prescribed subject areas on an annual basis. All staff are required to attend classes on: Abuse Policy, Infection Control/AIDS, Human Rights Policy, Body Mechanics and Lifting, Sexual Harassment, and the Heimlich Maneuver. In addition, direct care staff are required to receive annual training on: Active Treatment, Crisis Management, Adult CPR, and the Mandt System. (Attachment 12).



2. In addition to Adult CPR, NVTC will continue to conduct emergency medical response drills. (Attachment 13). The purpose of these drills is to allow all staff involved the opportunity to practice responding to mock medical emergencies to better prepare them for a real situation. Nursing staff coordinate, monitor, and evaluate these drills and send documentation to the Training Department.

3. Compliance with mandated training requirements will be monitored by the Training Department. Quarterly summaries of compliance rates with mandated training requirements are sent to the supervisors.

4. NVTC's curriculum on Client Record System and Documentation has been developed and will continue to be included in the Annual Retraining Program. Target date for implementation was June 30, 1995.

5. Recognizing that the skills and knowledge necessary for direct care staff assigned to different work sites will vary depending upon the specific needs of the clients, program managers are in the process of working with the Training Department to determine additional training requirements for direct care staff assigned to each unit. Building 7 began this pilot in late 1994 and began implementing its plan in January 1995. (See Attachment 14 for Building 7 Plan). All residential buildings will have completed plans by September 30, 1995.

C. Physical Management Training

Training the Physical Management curriculum "Challenges in Physical Management", as described in Pre-service Training, Paragraph A.9 above, will begin for direct care and clinical staff by January 31, 1996. Staff assigned to Units 1, 3A, 3C, 3D, and 5A will participate in more intense in-services and client specific training at their work sites. These in-services will be provided quarterly at a minimum. Whenever an individual client program is developed or modified, all staff will be trained on these changes.

D. Individual Behavioral Programming Training

1. During pre-service, staff receive training on Behavior Modification, Teaching Techniques (Task Analysis, Prompting, Reinforcement, Error Correction), Crisis Management, Behavioral Documentation, and Use of Mechanical Restraints. This training is meant to be general in nature and provide staff with the "tools" to be able to implement individualized program plans. However, staff are not permitted to implement program plans until they have received additional training on the individual plans.

2. Once an employee completes the pre-service program, he or she begins working on the assigned work site. If clients on the unit have behavior programs, the new staff member is not allowed to implement them until he or she has been properly trained by the psychologist or psychology assistant. The psychology staff will monitor the training of each new staff member in all aspects of the program (including the specific target behavior, the objective, how to prevent the behavior from occurring, what to do when the targeted behavior is displayed, the adaptive and reinforcement components of the program, and data collection requirements). NVTC policy also requires that staff be re-trained on all behavior programs whenever there are changes to the program or every six months, whichever comes first. This training is documented and forwarded to the Training Department for inclusion in each employee's training record.

3. As new behavior support plans are written and summarized on new forms (Client Behavior Profiles), as described in Section II.C above, these will become a quick study guide and training tool for staff. Completion date is January 31, 1996.

4. To further develop the knowledge of staff regarding behavioral principles, all direct care staff will be required to complete the "Basic Behavioral Principles and their Applications to People with Developmental Disabilities" software package previously mentioned in the section on Pre-service Training. The completion date for this training for Units 5C, 6, 7C, 8A, and 8C is October 31, 1995, and for Units 1, 3A, 3C, 3D, 5A, and 7A is June 30, 1996.

E. Feeding/Mealtime Training

1. The Training Department has begun providing and will continue to provide in-services on Active Treatment focusing on the mealtime activity. This training stresses the importance of implementing individual goals and objectives from the IHP into the meal experience. Staff are quizzed on their knowledge of individual client programs, followed by discussion and demonstration of how these client needs can be integrated and implemented before, during, and after each mealtime. NVTC has completed training on Units 1, 3D, 5A, 5C, 6, and 7A. Units 3C and 7C are scheduled to be completed by February 1, 1996. 3A will be completed by March 1, 1996, 8A by April 1, 1996 and 8C by May 1, 1996. All active treatment training will be complete by May 1, 1996.

2. A concentrated interdisciplinary effort around several mealtime issues was begun in the Fall of 1994. The goal is to create a mealtime environment and experience which is more normalizing and more enriching, as well as

therapeutic in nature. This is accomplished by evaluating the physical environment of the dining areas, the time and resources allocated to mealtimes, and the knowledge of staff in mealtime programs and issues of active treatment. Clinical staff have established days and times to be in the dining areas to assist, model, and provide feedback to staff on mealtime techniques and program implementation. This will continue on an on-going basis. Monitoring is to be done by building supervisory staff. Specific outcome measures will be established by the clinical departments, in conjunction with the I.D. Team, for each specific unit by October 31, 1995.

3. As client programs are developed and modified, direct care staff will continue to be trained in these individual program plans by the appropriate clinical staff. Such reviews are documented and become part of the employee's training record. Clinical staff regularly and periodically review general information as well as client-specific information with the staff. This is documented and forwarded to the Training Department for inclusion in the employee's training record.

4. NVTC has purchased a tutorial software package on Active Treatment which will be included in the pre-service program. All direct care staff will complete the tutorial by July 1, 1996.

F. Continuing Education for Professional Staff

1. NVTC has established minimum continuing education requirements for its clinical staff. (Attachment 15). These were established for professional positions for which there are no state mandated or licensing continuing education requirements. These were established by the appropriate department heads and were based on standards from other states. Clinical staff who attend a training event which meets a continuing education requirement send documentation of this to the Training Department and it is entered into their training record. Summaries of training are provided to the supervisors and employees upon request. This continuing education process will be ongoing.

2. Records will be kept on compliance with required continuing education and reported back to supervisors and the Quality Management Committee on a quarterly basis. Reports will begin with training completed by December 31, 1995.

## **V. PHYSICAL THERAPY AND OCCUPATIONAL THERAPY MANAGEMENT**

NVTC will provide clients with adequate physical management, including appropriate physical therapy and occupational therapy programs. In addition to staffing outlined in Section III, J and K, NVTC shall take the following steps to accomplish this:

### **A. Physical Therapy**

1. By March 30, 1995, NVTC will design and provide new wheelchairs and seating systems to 32 residents. (Attachments 16 and 18).
2. By March 30, 1995, NVTC will design and fit 19 new seating systems into current wheelchairs.
3. By December 31, 1996, NVTC will upgrade and/or replace the remaining third of individual wheelchairs. Provision of wheelchairs and wheelchair modifications will be based upon a professional assessment of those most in need; all adaptive equipment will be individualized and there will be a continual adaptation of wheelchairs and other equipment as individual needs change. (Attachments 16 and 18).
4. By March 30, 1995, NVTC will develop and staff an on-site workshop dedicated to wheelchair and positioning equipment.
5. By March 30, 1995, NVTC will complete modifications to the water heating system for the Hubbard Tank to permit staff to conduct hydrotherapy during cold weather months.
6. By June 30, 1996, NVTC will reevaluate all clients with fixed contractures and reassess their potential for improvement with consultation from orthopedic and physiatric consultants.
7. By June 30, 1995, NVTC will establish 24-hour positioning schedules for all clients in need of positioning on Unit 1 and Building 3:
  - a. By March 30, 1995, NVTC will begin taking photographs of clients in various positions, with accompanying written descriptions of the benefits of placement in each position. These photographs will be assembled in unit-based books for daily use.
  - b. By April 30, 1995, NVTC will implement completed positioning programs in Unit 1.

c. By June 30, 1995, NVTC will implement completed positioning programs in Building 3.

8. By July 1, 1996, NVTC will establish and implement a staff training course for physical management of clients who demonstrate challenging mealtime and positioning needs.

9. By July 1, 1995, NVTC will select a physical management training program following review of several physical management training packages by the Training Department, Director of Occupational Therapy, Director of Physical Therapy and Director of Center Programs.

10. By July 1, 1996, physical management training will become part of pre-service orientation for all new staff and yearly re-training will also be required.

**B. Occupational Therapy**

1. A new Director of Occupational Therapy Services was hired on July 18, 1994. The Director will not serve as program manager for any other Building or Unit at NVTC.

2. By December 31, 1995, NVTC will be established as an internship site for students in occupational therapy professional training programs.

3. By July 1, 1996, NVTC will complete a pilot project involving sensory-motor integration training/treatment for four clients. Data will be collected and assessed. If data shows positive benefits for clients, the training/treatment program will be implemented with other clients whose need for such training/treatment has been identified by professional staff.

**VI. NUTRITIONAL MANAGEMENT AND FEEDING**

NVTC will provide clients with adequate nourishment, identification of nutritional deficiencies and appropriate feeding programs and adaptive equipment for use at mealtimes. NVTC will take the following steps to accomplish this:

A. By April 1, 1995, NVTC developed and began pilot implementation of a Nutritional Risk Assessment Form.

1. Pilot testing, modification and refinement of the Nutritional Risk Assessment Form will be completed by December 31, 1995.

2. A Nutritional Risk Screening Assessment form has been completed for each resident determined by staff to have specialized nutritional and/or feeding needs, and such a form will be completed for each resident identified in the future with a specialized need. Training appropriate to the resident's needs, based upon nutritional risk assessment, will be conducted for all staff members having nutritional responsibility and/or feeding responsibilities with respect to the resident. It is understood that staff working with residents with the highest risk will be the first to receive the training.

B. By July 1, 1995, NVTC will establish one and one-half additional dietitian positions. By July 1, 1996, NVTC shall have on staff two and one-half Registered Dietitians.

C. By September 1, 1995, NVTC will have provided consultation to direct care and professional staff on Units 1 and Building 3 by a multi-disciplinary nutritional management team, including an occupational therapist, physical therapist, speech pathologist and dietitian. (Attachments 17 and 18).

D. By December 31, 1995, NVTC will receive equipment designated as needed to implement modifications identified by nutritional assessments. Items will include one weighing scale, specialized calipers to assess nutritional status and measuring boards.

E. By December 31, 1995, NVTC will purchase the adaptive equipment for use during meals which has been identified as needed by physical therapy and occupational therapy staff. (Attachments 16 and 18).

F. By July 1, 1995, NVTC will receive 30 dining room chairs and accompanying tables for mealtime use on Building 3.

G. By March 30, 1995, NVTC will install a dishwasher in the Building 3 dining room, so all adaptive equipment can be cleaned on-site.

H. By March 30, 1995, NVTC will install an answering machine in Dietary the Services office to permit units to report, at all hours, adaptive feeding equipment needs.

I. By July 1, 1996, NVTC will provide for diagrams and photographs of residents to be placed in the dining room next to each resident.

## VII. MEDICAL CARE

Residents will be provided with adequate medical care. In order to accomplish this, NVTC will:

### A. Quality Assurance

Implement a peer review mechanism for all disciplines involved in providing health services. The Quality Assurance Program for Health Services (Attachment 19) provides for systematic credentialing procedures, staff education, reviews of adverse events or outcomes by a Clinical Practice Review Committee, as well as for peer review for medical and nursing practitioners.

a. Medical peer review was initiated on November 4, 1994 and the process of this review will continue, with systemic refinements, as needed.

b. NVTC's medical director will serve on a committee which includes the Director of Resident Records in order to develop a system for monitoring and improving physician documentation in charts. This review and planning period will be completed by September 1, 1995.

### B. Medical Specialty Consultation

NVTC maintains a regular schedule of consultation with medical specialists. (See Attachment 7.) These include neurology, ENT, orthopedics, ophthalmology, psychiatry, physiatry, gastro-intestinal, podiatry, urology, cardiology, gynecology, dermatology and genetics. Recruitment for additional specialty medical consultants will continue, as needs are identified. Notes from these consultations will continue to be included in residents' records and a procedure for monitoring will be established by September 30, 1995. See also Section IX. Recordkeeping Section.

### C. Medical Management of Residents with Epilepsy

1. An interdisciplinary epilepsy committee developed and implemented a new charting system for the epilepsy clinic. (See Attachment 20.) Information from this charting will be incorporated into the new resident record system by March 30, 1995. A procedure for monitoring compliance with the requirement of inclusion of charting information into resident records will be established by September 30, 1995.

2. By December 31, 1995, semi-annual audits of antiepileptic drug prescribing practices will be conducted by the Pharmacy and Therapeutics Committee, which performs the functions of a drug utilization review committee. Information from these audits will be considered by the interdisciplinary epilepsy committee and will be submitted to the Quality Management Director. Appropriate monitoring and follow-up will occur, as necessary.

a. NVTC will emphasize use of monotherapy and deemphasize use of barbiturates and phenytoin.

b. The Pharmacy and Therapeutics Committee will continue to monitor the consistency of charting and medication adjustment/change in individuals with epilepsy and seizures.

c. One index of improved quality of life for clients receiving epileptic drugs has been identified as reduced use of helmets for clients with epilepsy. Monitoring of frequency of helmet use has shown a reduction of 38% in the use of helmets from 45 in 1989 to 28 in February, 1995. NVTC will rely upon controlled medication trials and ongoing monitoring of improvement to determine further appropriate reduction of helmet use. (Attachment 4).

3. Individual treatment protocols for status epilepticus will be implemented by September 30, 1995.

4. A videotape and brochures for staff and family education will be completed by the interdisciplinary epilepsy committee by October 30, 1995.

5. Beginning June 30, 1995, the interdisciplinary epilepsy committee will review epilepsy-related injuries, infirmity and hospital admissions on a quarterly basis and report its analysis of this data to the Quality Management Director.

6. Guidelines were developed in September, 1994 for nursing care of clients with seizures and for first aid by residential staff. Guidelines for residential staff were posted in October, 1994. (Attachment 21).

Compliance with these guidelines will be assessed through routine audits of individual charts by a procedure to be established by September 30, 1995.



**D. Emergency Responsiveness**

1. Monthly emergency responsiveness drills, involving nursing, security and residential staff, were begun in May, 1994. (Attachment 22). The nurse manager will monitor the monthly drill reports and forward the analysis of these results and recommendations to the Quality Management Director, beginning on September 30, 1995.
2. Documentation of response times of EMS personnel to 911 calls from NVTC and of NVTC nurses to on-campus emergencies was begun in May 1994. (Attachment 23). The nurse manager will monitor the response times of EMS and nursing staff members and will report the results of this monitoring to the Quality Management Director, beginning on June 30, 1995.
3. Emergency notification procedures were posted on residential units in October, 1994. (Attachments 24 and 25). Compliance with these procedures will be monitored by the nurse manager through chart audits, and compliance rates gathered from this monitoring will be submitted to the Quality Management Director, beginning on September 30, 1995.

**VIII. MEDICATION MANAGEMENT**

Beginning December 1, 1995, a semi-annual audit of psychotropic medication prescribing practices will be conducted by the Pharmacy and Therapeutics Committee, which performs the function of a drug utilization review committee, with the results of these audits transmitted to the Quality Management Director. Appropriate monitoring and follow-up will occur, as necessary.

1. Since mid-1989, NVTC's use of antipsychotic (neuroleptic) drugs has been reduced by 33%. As of December 31, 1994, 26 clients were receiving this class of drugs, in comparison with 39 residents five years previously. (Attachment 26).
2. The Dyskinesia Identification System: Condensed User Scale (DISCUS) was adopted for monitoring tardive dyskinesia and other side-effects of clients on psychotropic medications in August, 1993. (Attachment 27). Information from this instrument will be reviewed quarterly by the Pharmacy and Therapeutics Committee beginning in June, 1995. Information from this review will be submitted to the Quality Management Director.
3. The consulting psychiatrist and Medical Director will continue to serve as members of the Behavioral Management Committee.

4. NVTC will follow its policies and procedures regarding the use of psychotropic medication, e.g. NVTC Instruction 5302 on Psychotropic Medication (Attachment 28), Medical Plan for Psychotropic Drug Use, consent forms (Attachment 29) and Health Services Policy and Procedures (Attachment 30).

## **IX. RECORDKEEPING**

NVTC will develop and implement a system of records for each client, developed and maintained under the supervision of a qualified professional whose primary responsibility will be to properly maintain client records. Each record will be readily available to all staff and will contain current information with respect to the client's care, medical treatment, and training, and will be organized so as to enable those using it to render professional judgments in providing care, medical treatment, and training to the client. NVTC will require staff to utilize such records in making care, medical treatment, and training decisions.

NVTC has approved for implementation a new Client Records System, the "Source Oriented Medical Record with Integrated Progress Notes". Revision of the record system has been divided into five phases: I. Recruitment; II. Research and Development; III. Training; IV. Implementation, and V. Quality Management. Timetables for each section are outlined in Attachment 31. Phases I and II have been completed. NVTC's plan provides for:

- A. Recruitment of a qualified Health Information Manager. A new Director of Resident Records, was hired on August 22, 1994. This position will oversee implementation of the new client records system in 1995.
- B. Development of a new Client Records System: Following three months of reviewing the current records management system, site visits to other facilities, solicitation of input from facility staff and researching recordkeeping techniques, a new client record system was proposed. In November and December 1994, the proposal was presented to Resident Record Committee members, clinical and residential staff and Senior Staff. On December 20, 1994, the Source Oriented Medical Record with Integrated Progress notes was approved for use beginning June 30, 1995. Attachment 32 summarizes the system which has been accepted.
- C. The most significant change represented by the new client record system is the integrated progress note, "Interdisciplinary Note", section. In this centralized section, professional disciplines will be charting information pertaining to the client. (Attachment 33). Specific documentation instruction to staff include guidelines for all those making entries into the centralized progress notes and contain "prompts" for

entry of indicators such as "OT Monthly Notes" as a title (qualifier) for easy identification and review.

D. Training: Beginning in March, 1995, Medical Records staff, in conjunction with the Training Department, will begin training in the new records system. Small departmental groups have been targeted for individualized training. Training will require each staff member to convert an existing client record to the format created by the new records system. Instructional guides will be provided for each staff member. Training for all residential and clinical staff will be completed by June 30, 1995. Follow-up sessions will be scheduled, as needed.

E. Implementation: Since records will be revised during training sessions, facility-wide implementation of the new records system will be completed by June 30, 1995.

F. Quality Management: By June 30, 1995, the current Resident Records Quality Management Plan will be amended to include quality mechanisms for monitoring implementation of the new system. Amendments will include provisions for:

1. Establishing a random sampling of records from each unit for compliance review by the Medical Record department staff and members of the Resident Record Committee.
2. Completion of initial reviews for all units will be completed by September 30, 1995 and a schedule for ongoing reviews of compliance with requirements of the new system.
3. Establishing criteria for monitoring which include, at a minimum:
  - a. correct chart identification on each CRS;
  - b. correct record filing order;
  - c. correct chronological date order for documents;
  - d. entries made to the integrated progress notes which are prefaced with qualifiers stating the discipline documenting the note; and
  - e. correct use of double-sided progress notes.
4. Reporting results of each random sampling on a quarterly basis to the Quality Management Committee and the facility Resident Records Committee.

## **X. QUALITY MANAGEMENT PLAN**

NVTC will develop and annually update a Quality Management Plan that will monitor, document and evaluate implementation of the activities identified in this Plan. Attachment 34 is NVTC's Quality Management Plan for FY 94-95.

## **XI. COMMUNITY PLACEMENT**

A. NVTC will reduce the number of current clients at NVTC in accordance with the NVTC Community Integration Initiative developed in 1991 with the primary objective of reducing current (i.e. 1991) resident census from 270 to 200 persons. This will be accomplished by securing appropriate community-based placements for those clients it determines in accordance with professional judgment to be eligible and appropriate for such placement, subject to the procedures described in ¶ C below. Full implementation of the Community Initiative will occur by July 1, 1996. Attached is a description of the Community Initiative outlining timelines employed, schedule for continued downsizing, and the process that has been used and will be used to meet its objectives. (Attachment 35).

B. NVTC will annually assess the needs of all remaining residents at NVTC as follows:

1. The treatment team will annually assess in accordance with the exercise of professional judgment the needs of all residents at NVTC at the time of the development of the annual IHP to render an evaluation with respect to the appropriateness of continued placement at NVTC. Such assessments will occur more frequently if a change in the needs of the resident so indicates.

2. Subject to the provisions of ¶ 4, if all appropriate professionals employed by or under contract with the Commonwealth to assess a resident, including but not necessarily limited to the assigned interdisciplinary team, determine that NVTC is not an appropriate setting for a resident and that a resident would be more appropriately served in a community setting, appropriate professionals will, within a reasonable time thereafter, develop such plan as may be appropriate and feasible to provide necessary services to the resident in a community setting, and will place the resident in accordance with the plan within a reasonable time after such plan has been developed and can be feasibly implemented. Sound, prudent fiscal considerations, and generally accepted business practices may be used by NVTC in determining whether a plan to place a resident in the community is feasible and, if so, when such plan can be feasibly implemented. In no event will NVTC have an obligation under the Plan to discharge or transfer a resident before a

community setting that would more appropriately serve the resident has been identified and there is such a setting available.

3. In all decisions with respect to individual residents, the views and opinions of the individual resident, parent(s), guardian(s), other appropriate surrogate decision-maker(s) and professionals will be appropriately considered by NVTC. When it is determined that NVTC is not an appropriate setting for a resident, NVTC will ensure that the views and opinions of the individual resident, parent(s), guardian(s), appropriate surrogate decision-maker(s) and professionals will be considered when developing and implementing an appropriate and feasible discharge plan.

4. Where the consent of parent(s), guardian(s), or other surrogate decision-maker(s) is withheld regarding discharge or placement, in disagreement with the judgment of professionals employed by or under contract with the Commonwealth, NVTC will make its discharge and transfer decisions after consultation with the individual resident, parent(s), guardian(s) or other appropriate surrogate decision-maker(s) and, after such consultation, will engage in a good faith effort to reach a consensus as to what decision about discharge and/or placement is in the best interests of the individual NVTC resident in exercise of its discretion on a case-by-case basis. The parent(s), guardian(s) or other surrogate decision-maker(s) may present the opinion of a qualified professional(s) for consideration by NVTC with respect to discharge and/or placement decisions. If the NVTC decision is ultimately to retain the resident, NVTC will continue to involve the parent(s), guardian(s) or other surrogate decision-maker(s) in the treatment and discharge planning process and continue to make them aware of available opportunities in the community for the care of the resident through parental educational opportunities conducted by community providers.

## BEHAVIORAL PROGRAMS: 2/24/95

## ADAPTIVE BEHAVIORS

PB = ProSocial Behavior  
 GT = Gentle Touching  
 CL = Community Living  
 TR = Tolerate Refusals  
 CM = Choice Making  
 SS = Sensory Stimulation  
 AC = Appropriate Communication  
 AM = Accept Medication  
 OM = Object Manipulation  
 TT = Transition Training  
 CB = Cooperative Behavior  
 AM = Absence of Maladaptive Beh

## TRAINING PROCEDURES

DRO = Differential Reinforcement of Other Behaviors  
 DRI = Differential Reinforcement of Incompatible Behaviors  
 DRA = Differential Reinforcement of Appropriate Behaviors  
 CT = Communication Training  
 I/GC = Individual/Group Counseling  
 OB = Odor Board  
 RT = Relaxation Training  
 SS = Sensory Stimulation  
 IE = Item Exchange (Pica)  
 TE = Token Economy  
 LS = Level Systems  
 PP = Positive Practice

Note: In addition to specific training procedures, appropriate preventative procedures, including environmental factors, have been considered in the training programs.

## MALADAPTIVE BEHAVIORS

Wr = Wrapping  
 NC = NonCooperation  
 Sx = Sexual Behavior  
 Mo = Mouthing  
 St = Stealing  
 Sm = Smearing feces  
 Sp = Spitting  
 NS = Not Sitting (STC)  
 RR = Refuse to Return  
 Di = Disrobing  
 Hy = Hyperactivity  
 UD = Urinate/Defecate  
 TR = Tear or Remove Clothes  
 LWA = Leaving Without Approval  
 IS = Inappropriate Social Behavior  
 IP = Inappropriate Physical Behavior  
 Ta = Tantrum (yell, etc.)  
 Th = Threats of Agg  
 DB = Disruptive Behavior  
 Op = Oppositional Behavior  
 Agg = Aggression  
 pe/pr/se = People/Property/Self  
 Bi = Biting  
 Pica = Pica

## INTERVENTION PROCEDURES

NG = Nonremovable Garment  
 TG = Tear Resistant Garment  
 BR = Bedroom  
 QA = Quiet Area  
 QR = Quiet Room  
 TO = Time Out  
 Ex = Extinction  
 UR = Unit Restriction  
 PP = Personal Prop Restrict  
 Sh = Shadow  
 Bl = Block  
 SB = Seatbelt (STC)  
 CB = Communication Board  
 Re = Restitution  
 Co = Counseling  
 RC = Response Cost  
 SR = Self Restrain  
 Se = Self in QR  
 Mi = Placed on Mat  
 PR = Personal restraint  
 MR = Mechanical Restraint  
 CH = Contingent Helmet  
 NH = Noncontingent Helmet  
 NA = Noncontingent Arm Restri

Note: All interventions begin with verbal and nonphysical forms of interaction.

Agg = Aggression People/Property/Self (Agg pe/pr/se). Biting (Bi)  
 SIB = Self-Injurious Behavior (SIB)  
 Pica = (Pica)  
 Othr Agg = Tantrums (Ta), Disruptive Behaviors (DB), Threats of Aggression (Th), Spitting (Sp)  
 Othr = Other Behaviors

MR = Mechanical Restraints (i.e., 24 point cuff restraints, Arm restraints (NA), Seatbelt (SB))  
 PR = Personal Restraints (PR)  
 TO = Time - Out (TO)  
 Hint = Contingent Helmet (CH) and Noncontingent Helmet (NH)  
 U/P Rct = Unit Restriction (UR) and Personal Property Restriction (PP)  
 Br/Qt/r = Bedroom (BR), Quiet Area (QA), Quiet Room (QR)  
 Othr = Other Interventions

| Name | Fun<br>Anl | Rstr<br>Proc | Adaptive Behaviors       |                        | Maladaptive Behaviors             |     |     |      |             |      |                         |                    |    |    |      |            |             |      | Psy<br>Med |
|------|------------|--------------|--------------------------|------------------------|-----------------------------------|-----|-----|------|-------------|------|-------------------------|--------------------|----|----|------|------------|-------------|------|------------|
|      |            |              | Behaviors to<br>Increase | Training<br>Procedures | Maladaptive Behaviors to Decrease |     |     |      |             |      | Intervention Procedures |                    |    |    |      |            |             |      |            |
|      |            |              |                          |                        |                                   | Agg | SIB | Pica | Othr<br>Agg | Othr |                         | MR                 | PR | TO | Hlmt | U/P<br>Rct | Br/<br>Qa/r | Othr |            |
|      | 3A         |              | AC                       | DRA                    | Agg pe/pr                         | X   |     |      |             |      |                         | QR                 |    |    |      |            | X           |      |            |
|      | 3A         |              | CB                       | DRA                    | NC. UD                            |     |     |      |             | X    |                         | -----              |    |    |      |            |             |      | X          |
|      | 3A         | X            | CB                       | DRA                    | Ta                                |     |     |      | X           |      |                         | TO                 |    |    | X    |            |             |      |            |
|      | 3A         | X            | CB, AC                   | DRO, DRA               | Ta. Agg pe/pr                     | X   |     |      | X           |      |                         | QA, QR, Mi         |    |    |      |            | X           | X    |            |
|      | 3A         |              | PB                       | DRO                    | UD                                |     |     |      |             | X    |                         | RC, Co             |    |    |      |            |             | X    |            |
|      | 3C         |              | CB                       | DRA, DRI               | Pica, St. Agg pe                  | X   |     | X    |             |      |                         | Bi                 |    |    |      |            |             | X    |            |
|      | 3C         |              | PB                       | DRO                    | Mo. Sp                            |     |     |      | X           | X    |                         | -----              |    |    |      |            |             |      |            |
|      | 3C         |              | PB                       | DRO                    | Mo. IP                            |     |     |      |             | X    |                         | -----              |    |    |      |            |             |      |            |
|      | 3C         |              | PB, CB                   | DRA                    | RR. Agg pe/pr                     | X   |     |      |             | X    |                         | RC, QR             |    |    |      |            | X           | X    |            |
|      | 3C         | X            | PB, CB                   | DRI, DRA               | Agg se                            |     |     |      |             |      |                         |                    |    |    |      |            |             |      |            |
|      | 3C         | X            | PB                       | DRA                    | NC. Ta. Agg pe, Bi                | X   |     |      | X           | X    |                         | QR                 |    |    |      |            | X           |      |            |
|      | 3C         |              | PB                       | DRA                    | Mo. Sp                            |     |     |      | X           | X    |                         | -----              |    |    |      |            |             |      |            |
|      | 3D         |              | PB                       | DRA                    | Ta. Agg se                        | X   |     |      | X           |      |                         | Sh                 |    |    |      |            |             | X    |            |
|      | 3D         |              | PB                       | DRI                    | Pica, Bi, Mo                      |     |     | X    | X           | X    |                         | Bi                 |    |    |      |            |             | X    |            |
|      | 3D         |              | CB                       | DRA                    | Ta. Agg se                        | X   |     |      | X           |      |                         | QA, Sh             |    |    |      |            | X           | X    |            |
|      | 5A         |              | CB                       | DRA                    | Agg pe/pr, SIB                    | X   | X   |      |             |      |                         | QR, PR             |    | X  |      |            | X           |      | X          |
|      | 5A         |              | OM                       | DRA                    | IS. Agg pe                        | X   |     |      |             | X    |                         | QA                 |    |    |      |            | X           |      |            |
|      | 5A         | X            | CB                       | DRA                    | Ta. Agg pe/pr                     | X   |     |      | X           |      |                         | SR, QR             |    |    |      |            | X           | X    |            |
|      | 5A         |              | AM                       | DRO                    | UD. Pica, Agg pe/se               | X   |     | X    |             | X    |                         | Bi, Re, QR         |    |    |      |            | X           | X    |            |
|      | 5A         |              | AM                       | DRO                    | Mo. Agg pe                        | X   |     |      |             | X    |                         | QA                 |    |    |      |            | X           |      |            |
|      | 5A         |              | PB                       | DRA, DRO               | Agg pe                            | X   |     |      |             |      |                         | QA                 |    |    |      |            | X           |      |            |
|      | 5A         |              | CB                       | DRA                    | UD. Agg pe/se                     | X   |     |      |             | X    |                         | Bi, QA, Re         |    |    |      |            | X           | X    |            |
|      | 5A         |              | OM, AM                   | DRA, DRO               | SIB, Agg se                       | X   | X   |      |             |      |                         | Bi                 |    |    |      |            |             | X    | X          |
|      | 5C         |              | TT                       | DRA                    | Agg pe/pr/se                      | X   |     |      |             |      |                         | BR, QA, PR, CH     |    | X  |      | X          | X           |      |            |
|      | 5C         | X            | GT, PB                   | DRA                    | Ta. Agg pe/se, Bi                 | X   |     |      | X           |      |                         | QR, TO             |    |    | X    |            | X           |      |            |
|      | 5C         | X            | AC, TT                   | TE                     | DB, LWA, Agg se                   | X   |     |      | X           | X    |                         | Re, BR, PR, UR     |    | X  |      |            | X           | X    |            |
|      | 5C         | X            | CB, AM                   | DRO, DRA               | Agg pe, Bi                        | X   |     |      |             |      |                         | QR, TO, PR         |    | X  | X    |            | X           |      |            |
|      | 5C         | X            | CB, AM                   | DRO                    | DB, Th, Bi, Agg pe/pr             | X   |     |      | X           |      |                         | BR, QR, TO, CH, NH |    |    | X    | X          |             |      | X          |
|      | 5C         |              | AC                       | DRA                    | Agg pe/pr                         | X   |     |      |             |      |                         | QR                 |    |    |      |            | X           |      |            |
|      | 5C         |              | TT, CL                   | DRA                    | Agg pe/pr, Pica                   | X   |     | X    |             |      |                         | Bi, QR             |    |    |      |            | X           | X    |            |
|      | 5C         |              | CB, AM                   | DRO, TE                | DB, UD, TR, Agg pe/pr             | X   |     |      | X           | X    |                         | SR                 |    |    |      |            |             | X    |            |
|      | 5C         | X            | AC                       | DRA                    | Agg pe, SIB                       | X   | X   |      |             |      |                         | QR, TO, PR         |    | X  | X    |            | X           |      |            |
|      | 5C         |              | AC, CB                   | DRA                    | Ta. Agg pe, SIB                   | X   | X   |      | X           |      |                         | BR, QA             |    |    |      |            | X           |      |            |
|      | 5C         |              | CB, PB                   | DRA                    | -----                             |     |     |      |             |      |                         | -----              |    |    |      |            |             |      |            |
|      | 5C         |              | CB, TT                   | DRA                    | LWA, St. UD, Agg pe               | X   |     |      |             | X    |                         | Re, QR             |    |    |      |            | X           | X    | X          |

| Name | Fun<br>Anl | Rstr<br>Proc | Adaptive Behaviors       |                        | Maladaptive Behaviors             |                         |     |      |             |                         |   |                    |    |    | Psy<br>Med |      |             |             |      |   |
|------|------------|--------------|--------------------------|------------------------|-----------------------------------|-------------------------|-----|------|-------------|-------------------------|---|--------------------|----|----|------------|------|-------------|-------------|------|---|
|      |            |              | Behaviors to<br>Increase | Training<br>Procedures | Maladaptive Behaviors to Decrease |                         |     |      |             | Intervention Procedures |   |                    |    |    |            |      |             |             |      |   |
|      |            |              |                          |                        |                                   | Agg                     | SIB | Pica | Othr<br>Agg | Othr                    |   | MR                 | PR | TO |            | Hims | U/P<br>Rict | Br/<br>Qz/r | Othr |   |
|      | 5C         |              | X                        | PB. CP. SS. AM         | OB. DRA. DRO                      | Ta. UD. SIB. Agg pe/pr  | X   | X    |             | X                       | X | Re. QR. TO. PR     |    | X  | X          |      |             | X           | X    |   |
|      | 5C         |              |                          | CB. CM                 | DRA                               | DB. UD. Sa. Agg pe/ho   | X   |      |             | X                       | X | QR. Re             |    |    |            |      |             | X           | X    |   |
|      | 5C         |              | X                        | PB. AC                 | DRA                               | Ta. Sp. Agg pe/se. LWA  | X   |      |             | X                       | X | QR. TO. PR         |    | X  | X          |      |             | X           |      |   |
|      | 5C         |              |                          | CB. TT                 | DRA                               | Agg pe/pr               | X   |      |             |                         |   | QR                 |    |    |            |      |             | X           |      |   |
|      | 5C         |              |                          | GT. CB                 | DRA. TE                           | DB. Agg pe/pr           | X   |      |             | X                       |   | BR. QR             |    |    |            |      |             | X           |      |   |
|      | 5C         |              | X                        | CB. PB                 | DRA                               | Ta. Agg pe/se           | X   |      |             | X                       |   | TO. PP. Et         |    |    | X          |      | X           |             | X    |   |
|      | 6          | X            | X                        | PB. CB. AC             | DRA                               | Agg pe/pr/se            | X   |      |             |                         |   | TG. BR. QR. TO     |    |    | X          |      |             | X           | X    | X |
|      | 6          |              |                          | PB. CB. AC. AM         | DRA. DRO. UGC. LS                 | Agg pe/pr. St. LWA. Op  | X   |      |             |                         | X | BR. QR. Re         |    |    |            |      |             | X           | X    | X |
|      | 6          | X            | X                        | PB. CB. AC. TR         | DRA. Re                           | Agg pe/pr. UD           | X   |      |             |                         | X | Se. QR. TO. MR     | X  |    | X          |      |             | X           | X    | X |
|      | 6          |              |                          | PB. CB. AC             | DRA. UGC                          | NC. Agg pe/pr           | X   |      |             |                         | X | BR. QR             |    |    |            |      |             | X           |      |   |
|      | 6          |              | X                        | PB. CB. AC. TT         | DRA                               | Agg pe/pr. Di. UD. RR   | X   |      |             | X                       | X | Ex. QR. TO         |    |    | X          |      |             | X           | X    |   |
|      | 6          |              | X                        | PB. CB. AC             | DRA                               | Agg pe/pr/se. Bi        | X   |      |             | X                       |   | QR. TO             |    |    | X          |      |             | X           |      |   |
|      | 6          |              | X                        | PB. CB. AC. AM         | DRA. DRO                          | Ta. Agg pe/pr           | X   |      |             | X                       |   | QR. TO. Re         |    |    | X          |      |             | X           | X    |   |
|      | 6          |              | X                        | PB. CB. AC. AM         | DRA. DRO                          | Ta. Agg pe/pr/se. TR    | X   |      |             | X                       | X | NO. BR. QR. TO     |    |    | X          |      |             | X           | X    | X |
|      | 6          | X            | X                        | PB. CB. AC. TT. AM     | DRA. IE. DRO                      | Agg pe/pr. Bi. Pica. Si | X   |      | X           |                         | X | RC. QR. TO. NH     |    |    | X          | X    |             | X           | X    | X |
|      | 6          | X            | X                        | PB. CB. AC             | DRA                               | Agg pe/pr. Bi           | X   |      |             |                         |   | Ex. BR. QR. TO. CH |    |    | X          | X    |             | X           | X    |   |
|      | 6          |              |                          | PB. CB. AC             | DRA. CT                           | Agg pe/pr               | X   |      |             |                         |   | BR                 |    |    |            |      |             | X           |      |   |
|      | 6          | X            | X                        | PB. CB. AC. SS         | DRA. OB                           | SIB. Agg pe/pr. Di. Sm  | X   | X    |             |                         | X | BR. CH. MR         | X  |    |            | X    |             | X           |      |   |
|      | 6          | X            |                          | PB. CB. AC             | DRA                               | Ta. Agg pe/pr           | X   |      |             | X                       |   | BR. QR             |    |    |            |      |             | X           |      | X |
|      | 6          | X            |                          | PB. CB. AC             | DRA. UGC. RT                      | SIB. Agg pe             | X   | X    |             |                         |   | SR. QA. Re         |    |    |            |      |             | X           | X    | X |
|      | 7A         |              |                          | AC. PB                 | DRA                               | DB. Agg pe/pr           | X   |      |             | X                       |   | Sh. QA. QR         |    |    |            |      |             | X           | X    |   |
|      | 7A         |              |                          | AC. PB                 | DRA                               | Agg pe/pr               | X   |      |             |                         |   | QA. QR             |    |    |            |      |             | X           |      |   |
|      | 7A         |              |                          | AC. GT. PB. CB         | DRA                               | SIB                     |     | X    |             |                         |   | SR                 |    |    |            |      |             |             | X    |   |
|      | 7A         |              |                          | AC. PB. GT. CB         | DRA                               | Agg pe/se               | X   |      |             |                         |   | Sh. QA. QR         |    |    |            |      |             | X           | X    | X |
|      | 7A         | X            |                          | GT. PB. AC             | DRA                               | Sp. Th. Agg pe/pr       | X   |      |             | X                       |   | QA. QR. Re         |    |    |            |      |             | X           | X    |   |
|      | 7A         |              |                          | TT. AC. PB. CB         | DRA                               | Agg pe/pr               | X   |      |             |                         |   | Re. QA. QR         |    |    |            |      |             | X           | X    |   |
|      | 7A         | X            | X                        | GT. PB. AC             | DRA                               | Ta. Agg pe/se           | X   |      |             | X                       |   | Se. QA. QR. TO     |    |    | X          |      |             | X           | X    |   |
|      | 7A         |              |                          | AC. PB                 | DRA                               | TR. Agg pe              | X   |      |             |                         |   | QA. QR. SR         |    |    |            |      |             | X           | X    | X |
|      | 7A         |              | X                        | AC. GT. PB. CB         | DRA                               | Ta. Agg pe/pr. SIB      | X   | X    |             | X                       |   | QA. QR. SR. CH     |    |    |            | X    |             | X           | X    | X |
|      | 7A         |              |                          | AC. PB. CB             | DRA                               | Hy. Agg pe. IS          | X   |      |             |                         | X | QA. QR. CB         |    |    |            |      |             | X           | X    |   |
|      | 7A         | X            | X                        | AC. PB. TT             | DRA                               | TR. Th. LWA. Agg pe/pr  | X   |      |             | X                       | X | QA. QR. TO. Re     |    |    | X          |      |             | X           | X    |   |
|      | 7C         |              | X                        | PB. TT                 | DRA                               | Agg pe. Pica            | X   |      | X           |                         |   | SR. MR             | X  |    |            |      |             |             | X    |   |
|      | 7C         |              |                          | TT. AC. CL             | DRA                               | TR. Di. Agg pe          | X   |      |             |                         | X | NG. QR             |    |    |            |      |             | X           | X    |   |
|      | 7C         |              | X                        | TT. AC. GT. PB         | DRA                               | SIB. Agg pe/pr          | X   | X    |             |                         |   | SR. QA. CH. MR. PR | X  | X  |            | X    |             | X           | X    | X |
|      | 7C         |              | X                        | CL. TT. PB. CL         | DRA                               | LWA. Agg pe. Di         | X   |      |             |                         | X | QA. QR. TO. NG     |    |    | X          |      |             | X           | X    | X |



| Name | Fun<br>Anl | Restr<br>Proc | Adaptive Behaviors       |                        | Maladaptive Behaviors             |                       |     |      |             |                         |    |                    |    |    |      |            |             |      | Psy<br>Med |       |
|------|------------|---------------|--------------------------|------------------------|-----------------------------------|-----------------------|-----|------|-------------|-------------------------|----|--------------------|----|----|------|------------|-------------|------|------------|-------|
|      |            |               | Behaviors to<br>Increase | Training<br>Procedures | Maladaptive Behaviors to Decrease |                       |     |      |             | Intervention Procedures |    |                    |    |    |      |            |             |      |            |       |
|      |            |               |                          |                        |                                   | Agg                   | SIB | Pica | Othr<br>Agg | Othr                    |    | MR                 | PR | TO | Hlmt | U/P<br>Rct | Br/<br>Qa/r | Othr |            |       |
|      | 7C         | X             | X                        | GT. PB                 | DRA                               | Agg pe/pr. SIB. Pica  | X   | X    | X           |                         |    | QA. QR. MR. CH     | X  |    |      | X          |             | X    |            | X     |
|      | 7C         |               | X                        | PB. AC. CL             | DRA                               | Ta. Di. Agg pe        | X   |      |             | X                       | X  | QA. QR. TO         |    |    | X    |            | X           |      |            |       |
|      | 7C         |               |                          | AC. PB                 | DRA                               | Ta. NC. Pica. Agg pe  | X   |      | X           | X                       | X  | BR                 |    |    |      |            | X           |      |            | X     |
|      | 7C         |               |                          | TT. CB                 | DRA                               | Agg pe/pr. DB         | X   |      |             | X                       |    | QA. QR             |    |    |      |            | X           |      |            | X     |
|      | 7C         | X             |                          | GT. PB                 | DRA                               | Agg pe/pr/se. DB. SIB | X   | X    |             | X                       |    | QA. QR. TO. CH. MR | X  |    | X    | X          | X           |      |            |       |
|      | 7C         |               |                          | GT. TT. AC             | DRA                               | LWA. Agg se           | X   |      |             |                         | X  | QA. QR             |    |    |      |            | X           |      |            | X     |
|      | 7C         |               |                          | TT. AC. PB             | DRA                               | DB. Agg pe            | X   |      |             | X                       |    | QR. QA             |    |    |      |            | X           |      |            |       |
|      | 7C         |               |                          | PB. GT. AC             | DRA                               | NC. Ta. Bl. Agg pe    | X   |      |             | X                       | X  | QA. QR             |    |    |      |            | X           |      |            |       |
|      | 7C         |               | X                        | PB. GT. AC             | DRA                               | St. Agg pe. Pica. DB  | X   |      | X           | X                       | X  | QA. QR. TO. PR. SB | X  | X  | X    |            | X           |      |            |       |
|      |            |               |                          | CB. PB                 | DRA. DRI                          | Agg pe                | X   |      |             |                         |    | QR                 |    |    |      |            | X           |      |            |       |
|      | 8A         |               | X                        | AC. CB                 | DRA. DRI                          | Agg pe/pr. IS. Op     | X   |      |             |                         | X  | Re. QR. PR         |    | X  |      |            | X           | X    |            |       |
|      | 8A         | X             | X                        | PB. CB. AC. AM         | DRA. DRO. DRI                     | Ta. Agg pe. SIB. Wr   | X   | X    |             | X                       | X  | RC. QR. CH. MR     | X  |    |      | X          | X           | X    |            | X     |
|      | 8A         |               | X                        | CB. PB. AC. AM         | CT. DRO. DRA                      | Agg pe/se             | X   |      |             |                         |    | QR. TO             |    |    | X    |            | X           |      |            | X     |
|      | 8A         | X             | X                        | AC. PB. AM             | DRO. DRA                          | Ta. Agg pe/pr/se. Bi  | X   |      |             | X                       |    | RC. BR. QR. TO     |    |    | X    |            | X           | X    |            | X     |
|      | 8A         |               | X                        | CB. PB. AM             | DRO. DRA                          | Agg pe/pr             | X   |      |             |                         |    | QA. OR             |    |    |      |            | X           |      |            | X     |
|      | 8A         |               |                          | CB. PB. AM             | DRO. DRA                          | Ta. Agg pe            | X   |      |             | X                       |    | SR                 |    |    |      |            |             | X    | X          | X     |
|      | 8A         |               |                          | CB. AC. PB. CL. AM     | DRO. DRA                          | Agg pe/pr             | X   |      |             |                         |    | SR                 |    |    |      |            |             | X    | X          | X     |
|      | 8C         |               |                          | AC. CB. PB             | Re. I/GC. DRA. DRI                | -----                 |     |      |             |                         |    | -----              |    |    |      |            |             |      |            | x(id) |
|      | 8C         |               | X                        | CB. CL. AC. PB. AM     | DRO. I/GC. DRA                    | Op. Th. Ss. Agg pe/pr | X   |      |             | X                       | X  | BR. QR. TO. PR     |    | X  | X    |            | X           |      |            |       |
|      | 8C         | X             | X                        | CB. PB. AC. AM         | PP. Re. DRA. DRO                  | Di. Agg pe/pr/se      | X   |      |             |                         | X  | SR. QR. TO         |    |    | X    |            | X           | X    |            | X     |
|      | 8C         |               |                          | PB                     | I/GC. DRA                         | Op. Agg pe/pr/se      | X   |      |             |                         | X  | -----              |    |    |      |            |             |      |            | X     |
|      | 8C         |               |                          | CB. PB. AM             | I/GC. DRO. DRA                    | NC. IS                |     |      |             |                         | X  | BR. Co             |    |    |      |            | X           | X    |            |       |
|      | 8C         |               | X                        | CB. PB. AM             | DRO. DRA                          | Ta. Agg pe/pr/se      | X   |      |             | X                       |    | QR. PR             |    | X  |      |            | X           |      |            |       |
|      | 8C         |               |                          | PB. CB                 | Re. DRI. DRA                      | -----                 |     |      |             |                         |    | -----              |    |    |      |            |             |      |            | X     |
|      | 8C         |               |                          | CB. PB. AM             | DRA. DRO                          | Agg pe/pr             | X   |      |             |                         |    | QR                 |    |    |      |            | X           |      |            |       |
|      | 8C         | X             | X                        | CB. PB. AC. AM         | DRO. DRA. I/GC                    | Agg pe. SIB           | X   | X    |             |                         |    | RC. BR. MR         | X  |    |      |            | X           | X    |            | X     |
|      | 8C         | X             | X                        | CB. PB. AC. AM         | DRO. DRA. Re. I/GC                | Ta. Agg pe/pr         | X   |      |             | X                       | X  | QR. TO. PR         |    | X  | X    |            | X           |      |            | X     |
|      | 8C         |               | X                        | CB. PB. AM             | DRO. DRA. I/GC                    | Agg pe/pr/se          | X   |      |             |                         |    | Re. QA. QR. PR     |    | X  |      |            | X           | X    |            |       |
| 100  | 23         | 41            | 100                      | 100                    | 100                               | 86                    | 15  | 9    | 43          | 41                      | 99 | 10                 | 14 | 27 | 10   | 2          | 78          | 51   | 33         |       |

Note: In the 2nd column, the clients identified as having restrictive behavioral procedures may or may not also be receiving psychotropic medication as part of their total treatment program.

Ellen Babbitt (8C) receives psychotropic medication for management of Tardive Dyskinesia.

Functional analyses have been conducted for other clients who either have been discharged or no longer have a behavioral program.

**MALADAPTIVE BEHAVIOR FREQUENCY & DURATION FOR 1989**  
 See BDI/AVK/MAI PROGRAMS for definitions of interventions)

| Name          | MR        |          | PR        |          | TO        |          | W/AD/XX   |          |
|---------------|-----------|----------|-----------|----------|-----------|----------|-----------|----------|
|               | Frequency | Duration | Frequency | Duration | Frequency | Duration | Frequency | Duration |
| [REDACTED] 3A |           |          |           |          |           |          | 6         | 56       |
| [REDACTED] 3A |           |          |           |          | 2         | 23       |           |          |
| [REDACTED] 3A |           |          |           |          |           |          | 3         | 19       |
| [REDACTED] 3C |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 3C |           |          |           |          |           |          | 5         | 47       |
| [REDACTED] 3D |           |          |           |          |           |          | 1         | 2        |
| [REDACTED] 5A |           |          | 0         | 0        |           |          | 0         | 0        |
| [REDACTED] 5A |           |          |           |          |           |          | 1         | 2        |
| [REDACTED] 5A |           |          |           |          |           |          | 3         | 15       |
| [REDACTED] 5A |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 5A |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 5A |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 5A |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 5C |           |          | 2         | 9        |           |          | 4         | 55       |
| [REDACTED] 5C |           |          |           |          | 10        | 215      | 22        | 340      |
| [REDACTED] 5C |           |          | 1         | 3        |           |          | 1         | 12       |
| [REDACTED] 5C |           |          | 0         | 0        | 8         | 89       | 0         | 0        |
| [REDACTED] 5C |           |          |           |          | 28        | 436      | 58        | 789      |
| [REDACTED] 5C |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 5C |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 5C |           |          | 0         | 0        | 2         | 25       | 0         | 0        |
| [REDACTED] 5C |           |          |           |          |           |          | 1         | 5        |
| [REDACTED] 5C |           |          |           |          |           |          | 1         | 5        |
| [REDACTED] 5C |           |          |           |          |           |          | 0         | 51       |
| [REDACTED] 5C |           |          | 0         | 0        | 6         | 50       | 11        | 81       |
| [REDACTED] 5C |           |          |           |          |           |          | 3         | 27       |
| [REDACTED] 5C |           |          | 0         | 0        | 11        | 114      | 14        | 88       |
| [REDACTED] 5C |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 5C |           |          |           |          |           |          | 2         | 10       |
| [REDACTED] 6  |           |          |           |          | 7         | 73       |           |          |
| [REDACTED] 6  |           |          |           |          | 2         | 37       | 7         | 51       |
| [REDACTED] 6  |           |          |           |          |           |          | 2         | 20       |
| [REDACTED] 6  | 3         | 245      |           |          | 0         | 0        | 1         | 9        |
| [REDACTED] 6  |           |          |           |          |           |          | 6         | 144      |
| [REDACTED] 6  |           |          |           |          | 21        | 479      | 43        | 442      |
| [REDACTED] 6  |           |          |           |          | 0         | 0        | 59        | 838      |
| [REDACTED] 6  |           |          |           |          | 2         | 12       | 31        | 231      |
| [REDACTED] 6  |           |          |           |          | 4         | 45       | 16        | 200      |
| [REDACTED] 6  |           |          |           |          | 0         | 0        | 0         | 0        |
| [REDACTED] 6  |           |          |           |          | 8         | 99       | 43        | 450      |
| [REDACTED] 6  |           |          |           |          |           |          | 47        | 269      |
| [REDACTED] 6  | 36        | 1083     |           |          |           |          | 8         | 184      |
| [REDACTED] 6  |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 6  |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 7A |           |          |           |          |           |          | 6         | 64       |
| [REDACTED] 7A |           |          |           |          |           |          | 2         | 16       |
| [REDACTED] 7A |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 7A |           |          |           |          |           |          | 0         | 0        |
| [REDACTED] 7A |           |          |           |          |           |          | 12        | 122      |
| [REDACTED] 7A |           |          |           |          | 0         | 0        | 17        | 336      |
| [REDACTED] 7A |           |          |           |          |           |          | 1         | 5        |
| [REDACTED] 7A |           |          |           |          |           |          | 7         | 138      |
| [REDACTED] 7A |           |          |           |          |           |          | 1         | 10       |
| [REDACTED] 7A |           |          |           |          | 0         | 0        | 16        | 477      |

\* Duration is in minutes

| Name         |    | MR        |          | PR        |          | TO        |          | H/A/UnA/H |          |
|--------------|----|-----------|----------|-----------|----------|-----------|----------|-----------|----------|
|              |    | Frequency | Duration | Frequency | Duration | Frequency | Duration | Frequency | Duration |
| Dependent ** | 7C | 0         | 0        |           |          |           |          | 10        | 49       |
| Dependent    | 7C |           |          |           |          |           |          | 21        | 75       |
| Dependent    | 7C | 7         | 111      | 3         | 34       |           |          | 5         | 41       |
| Dependent    | 7C |           |          |           |          | 0         | 0        |           |          |
| Dependent ** | 7C | 0         | 0        |           |          |           |          |           |          |
| Dependent    | 7C | 5         | 78       |           |          |           |          | 0         | 0        |
| Dependent    | 7C |           |          |           |          | 20        | 213      | 55        | 314      |
| Dependent    | 7C |           |          |           |          |           |          | 0         | 0        |
| Dependent    | 7C |           |          |           |          |           |          | 0         | 0        |
| Dependent    | 7C | 31        | 1000     |           |          | 6         | 105      | 22        | 119      |
| Dependent    | 7C |           |          |           |          |           |          | 0         | 0        |
| Dependent    | 7C |           |          |           |          |           |          | 19        | 124      |
| Dependent    | 7C |           |          |           |          |           |          | 3         | 18       |
| Dependent    | 7C | 8         | 155      | 10        | 43       | 9         | 39       | 15        | 90       |
| Dependent    | RA |           |          |           |          |           |          | 11        | 176      |
| Dependent    | RA |           |          | 26        | 98       |           |          | 10        | 51       |
| Dependent    | RA | 37        | 1500     |           |          |           |          | 27        | 952      |
| Dependent    | RA |           |          |           |          | 4         | 58       | 17        | 198      |
| Dependent    | RA |           |          |           |          | 1         | 3        | 1         | 7        |
| Dependent    | RA |           |          |           |          |           |          | 5         | 40       |
| Dependent    | RC |           |          | 0         | 0        | 1         | 10       | 2         | 20       |
| Dependent    | RC |           |          |           |          | 10        | 63       | 71        | 589      |
| Dependent    | RC |           |          |           |          |           |          | 0         | 0        |
| Dependent    | RC |           |          | 4         | 15       |           |          | 5         | 10       |
| Dependent    | RC |           |          |           |          |           |          | 0         | 0        |
| Dependent    | RC | 0         | 0        |           |          |           |          | 0         | 0        |
| Dependent    | RC |           |          | 0         | 0        | 1         | 10       | 1         | 1        |
| Dependent    | RC |           |          | 2         | 12       |           |          | 1         | 3        |
| 82           |    | 127       | 4172     | 48        | 234      | 163       | 2190     | 793       | 8687     |
|              |    | Avg Drtn  | 32.9     | Avg Drtn  | 4.9      | Avg Drtn  | 13.4     | Avg Drtn  | 11.0     |

11/10/80

\*\* Noncontingent Restraints (not entered into frequency or duration measures).

## UNIT OBSERVATION FORM

ATTACHMENT

2

Location: \_\_\_\_\_ Date: \_\_\_\_\_  
Observer: \_\_\_\_\_ Facility: \_\_\_\_\_Area: \_\_\_\_\_  
Activity: \_\_\_\_\_  
Time: \_\_\_\_\_ SUMMARY

|                     |                          |  |  |  |
|---------------------|--------------------------|--|--|--|
| 1. Environment:     | 1) Cleanliness           |  |  |  |
|                     | 2) Safety                |  |  |  |
|                     | 3) Supplies/Materials    |  |  |  |
|                     | 4) Supervision           |  |  |  |
| 2. Client Condition | Number                   |  |  |  |
|                     | 1) Grooming              |  |  |  |
|                     | 2) Clothing              |  |  |  |
|                     | 3) Free from Restraint   |  |  |  |
|                     | 4) Free from Injury      |  |  |  |
| 3. Client Activity  | Number                   |  |  |  |
|                     | 1) Appropriate Social    |  |  |  |
|                     | 2) Appropriate Nonsocial |  |  |  |
|                     | 3) Inappropriate         |  |  |  |
|                     | 4) No Activity           |  |  |  |
| 4. Staff Activity   | Number                   |  |  |  |
|                     | 1) Client Care           |  |  |  |
|                     | 2) Training              |  |  |  |
|                     | 3) Client Positive       |  |  |  |
|                     | 4) Client Negative       |  |  |  |
|                     | 5) Non-Client Work       |  |  |  |
|                     | 6) Off-Task              |  |  |  |

CUES

## 1. Environment:

- 1) Cleanliness: Score 1-4 if presence of unnecessary trash, food, or containers on floor or furniture; unstored linen or clothing. Score 1-4 otherwise.  
 2) Safety: Score 1-4 if broken furniture, toxins, glass, or other dangerous items within reach; presence of structural hazards. Score 1-4 otherwise.  
 3) Supplies/materials: Score 1-4 if materials relevant to the activity are available in reasonable quantity. Score 1-4 otherwise.  
 4) Supervision: Score 1-4 if there is at least one staff member present. Score 1-4 otherwise.

## 2. Client Condition (Observe individuals clockwise, and place hatchmark on data sheet):

Number: indicate number of clients present.

- 1) Grooming: indicate number of clients who appear appropriately groomed (not soiled, absence of obvious dirt, hair clean).  
 2) Clothing: indicate number of clients wearing at least shirt and pants (or dress) and shoes.  
 3) Free from restraint: indicate number of clients not wearing restraints or protective equipment for behavior control. Exclude seizure helmets, slits, etc.  
 4) Free from injury: indicate number of clients who do not have an obvious current injury: open wound or laceration, bruise, laceration, bite, etc.

## 3. Client Activity (Observe individuals clockwise, note first behavior to occur, and place hatchmark on data sheet):

Number: indicate number of clients present.

- 1) Appropriate social: indicate number involved in either client-staff or client-client interaction: conversation, receiving instruction or care, sharing, play.  
 2) Appropriate nonsocial: indicate number who are exhibiting appropriate behavior but not interacting with another: working, self-care, interacting with materials in an appropriate manner, include television if client is visually attending.  
 3) Inappropriate: indicate number engaging in inappropriate behavior: self-harm, aggression, stereotypy, destruction, running away, etc.).  
 4) No activity: Score only if client has not engaged in a-c at the end of 20 sec.

## 4. Staff Activity (Observe individuals clockwise, note first behavior to occur, and place hatchmark on data sheet):

Number: indicate number of staff present.

- 1) Client care: indicate number providing direct client care (noninstructional): assistance with self-care, carrying or assisting with transition, etc. Also score as client positive or negative.  
 2) Training: indicate number providing instructional activities. Also score as client positive or negative.  
 3) Client positive: indicate number engaged in positive interaction with clients: conversation, praise, play, affection, giving "do" instruction, etc.  
 4) Client negative: indicate number engaged in negative interaction with clients: administration of punishment or reprimand, giving "don't do" instruction, response interruption or other form of physical intervention, etc.  
 5) Non-client work: indicate number involved in maintenance of unit, paperwork, work-related staff interaction, etc.  
 6) Off-task: Score only if staff has not engaged in a-e at the end of 20 sec.

# UNIT OBSERVATION FORM

Location: \_\_\_\_\_ Date: \_\_\_\_\_  
Observer: \_\_\_\_\_ Frequency: \_\_\_\_\_

Area: \_\_\_\_\_

Activity: \_\_\_\_\_

Time: \_\_\_\_\_

SUMMARY

## 1. Environment:

1) Cleanliness

2) Safety

3) Supplies/Materials

4) Supervision

## 2. Client Condition

Number

1) Grooming

2) Clothing

3) Free from Restraint

4) Free from Injury

## 3. Client Activity

Number

1) Appropriate Social

2) Appropriate Nonsocial

3) Inappropriate

4) No Activity

## 4. Staff Activity

Number

1) Client Care

2) Training

3) Client Positive

4) Client Negative

5) Non-Client Work

6) Off-Task

Notes

## 1. Environment:

1) Cleanliness: Score (+) if presence of unreflected trash, food, or containers on floor or furniture; unsorted linen or clothing. Score (-) otherwise.

2) Safety: Score (+) if broken furniture; toxins, glass, or other dangerous items which reflect presence of structural hazards. Score (-) otherwise.

3) Supplies/materials: Score (+) if materials relevant to the activity are available in reasonable quantity. Score (-) otherwise.

4) Supervision: Score (+) if there is at least one staff member present. Score (-) otherwise.

## 2. Client Condition (Observe individuals clockwise, and place hatchmark on data sheet):

Number: Indicate number of clients present.

1) Grooming: Indicate number of clients who appear appropriately groomed (not soiled, absence of obvious dirt, hair clean).

2) Clothing: Indicate number of clients wearing at least shirt and pants (or dress) and shoes.

3) Free from restraint: Indicate number of clients not wearing restraints or protective equipment for behavior control. Exclude seizure helmets, cuffs, etc.

4) Free from injury: Indicate number of clients who do not have an obvious current injury: open wound or scab, bruise, laceration, cyst, etc.

## 3. Client Activity (Observe individuals clockwise, note first behavior to occur, and place hatchmark on data sheet):

Number: Indicate number of clients present.

1) Appropriate social: Indicate number involved in either client-staff or client-client interaction: conversation, receiving instruction or care, sharing, play.

2) Appropriate nonsocial: Indicate number who are exhibiting appropriate behavior but not interacting with another: working, self-care, interacting with materials in an appropriate manner, include television if client is visually attending.

3) Inappropriate: Indicate number engaging in inappropriate behavior: self-harm, aggression, stereotypy, destruction, running away, etc.).

4) No activity: Score only if client has not engaged in a-c at the end of 30 sec.

## 4. Staff Activity (Observe individuals clockwise, note first behavior to occur, and place hatchmark on data sheet):

Number: Indicate number of staff present.

1) Client care: Indicate number providing direct client care (noninstructional): assistance with self-care, carrying or assisting with transition, etc. Also score as client positive or negative.

2) Training: Indicate number providing instructional activities. Also score as client positive or negative.

3) Client positive: Indicate number engaged in positive interaction with clients: conversation, praise, play, affection, giving "do" instruction, etc.

4) Client negative: Indicate number engaged in negative interaction with clients: administration of punishment or reprimand, giving "don't do" instruction, response interruption or other form of physical intervention, etc.

Non-client work: Indicate number involved in maintenance of unit, paperwork, work-related staff interaction, etc.

6) Off task: Score only if staff has not engaged in a-e at the end of 30 sec.

# UNIT OBSERVATION FORM

Location: \_\_\_\_\_ Date: \_\_\_\_\_  
Observer: \_\_\_\_\_ Frequency: \_\_\_\_\_

| Area:               |                          | Activity: |  | Time: |  | Summary |  |
|---------------------|--------------------------|-----------|--|-------|--|---------|--|
| 1. Environment      | 1) Cleanliness           |           |  |       |  |         |  |
|                     | 2) Safety                |           |  |       |  |         |  |
|                     | 3) Supplies/Materials    |           |  |       |  |         |  |
|                     | 4) Supervision           |           |  |       |  |         |  |
| 2. Client Condition | Number                   |           |  |       |  |         |  |
|                     | 1) Grooming              |           |  |       |  |         |  |
|                     | 2) Clothing              |           |  |       |  |         |  |
|                     | 3) Free from Restraint   |           |  |       |  |         |  |
| 3. Client Activity  | Number                   |           |  |       |  |         |  |
|                     | 1) Appropriate Social    |           |  |       |  |         |  |
|                     | 2) Appropriate Nonsocial |           |  |       |  |         |  |
|                     | 3) Inappropriate         |           |  |       |  |         |  |
| 4. Staff Activity   | Number                   |           |  |       |  |         |  |
|                     | 1) Client Care           |           |  |       |  |         |  |
|                     | 2) Training              |           |  |       |  |         |  |
|                     | 3) Client Positive       |           |  |       |  |         |  |
|                     | 4) Client Negative       |           |  |       |  |         |  |
|                     | 5) Non-Client work       |           |  |       |  |         |  |
| Notes               |                          |           |  |       |  |         |  |

## 1. Environment:

- 1) Cleanliness: Score (+) if presence of uneaten food, trash, or containers on floor or furniture; unscored linen or clothing. Score (-) otherwise.
- 2) Safety: Score (+) if broken furniture, toxins, glass, or other dangerous items within reach; presence of structural hazards. Score (-) otherwise.
- 3) Supplies/materials: Score (+) if materials relevant to the activity are available in reasonable quantity. Score (-) otherwise.
- 4) Supervision: Score (+) if there is at least one staff member present. Score (-) otherwise.

## 2. Client Condition (Observe individuals clockwise, and place mark on data sheet):

Number: indicate number of clients present.

- 1) Grooming: indicate number of clients who appear appropriately groomed (not soiled, absence of obvious dirt, hair clean).
- 2) Clothing: indicate number of clients wearing at least shirt and pants (or dress) and shoes.
- 3) Free from restraint: indicate number of clients not wearing restraints or protective equipment for behavior control. Exclude seizure helmets, casts, etc.
- 4) Free from injury: indicate number of clients who do not have an obvious current injury, open wound or scab, bruise, laceration, cast, etc.

## 3. Client Activity (observe individuals clockwise, note first behavior to occur, and place mark on data sheet):

Number: indicate number of clients present.

- 1) Appropriate social: indicate number involved in either client-staff or client-client interaction: conversation, receiving instruction or care, sharing, play.
- 2) Appropriate nonsocial: indicate number who are exhibiting appropriate behavior but not interacting with another: working, self-care, interacting with materials in an appropriate manner, include television if client is visually attending.
- 3) Inappropriate: indicate number engaging in inappropriate behavior: self-injury, aggression, stereotypy, destruction, running away, etc.
- 4) No activity: Score only if client has not engaged in a-c at the end of 30 sec.

## 4. Staff Activity (observe individuals clockwise, note first behavior to occur, and place mark on data sheet):

Number: indicate number of staff present.

- 1) Client care: indicate number providing direct client care (noninstructional): assistance with self-care, carrying or assisting with transition, etc. Also score as client positive or negative.
- 2) Training: indicate number providing instructional activities. Also score as client positive or negative.
- 3) Client positive: indicate number engaged in positive interaction with clients: conversation, praise, play, affection, giving "to do" instruction, etc.
- 4) Client negative: indicate number engaged in negative interaction with clients: administration of punishment or reprimand, giving "don't do" instruction, response interruption or other form of physical intervention, etc.
- 5) Non-client work: indicate number involved in maintenance of unit, paperwork, work-related staff interaction, etc.
- 6) Off task: Score only if staff has not engaged in a-e at the end of 30 sec.

NORTHERN VIRGINIA TRAINING CENTER  
Fairfax, Virginia

ATTACHMENT  
3

November 1, 1994

NVTC INSTRUCTION 5300

TO: Staff

SUBJECT: *Restrictive Procedures*

- I. Purpose. To define restrictive procedures at NVTC and to specify philosophy of use of restrictive procedures with clients.
- II. Cancellation. NVTC Instruction 5300 dated September 1, 1992 is hereby canceled.
- III. Definition. A restrictive procedure is defined as any procedure which:
  - A. Restricts a client's freedom of movement and/or
  - B. Limits access to activities, objects or events to which a client would otherwise be entitled as a part of his/her human rights and/or
  - C. Requires a client to perform a specific behavior, such as an over correction procedure, and/or
  - D. Results in altered states of consciousness (see NVTC Instruction 5302, Psychotropic Medication).
- IV. Philosophy. It is the policy and philosophy of NVTC to emphasize positive approaches to behavior management, the least restrictive interventions for each individual client and to ensure the protection of each individual's rights when restrictive procedures are utilized. The least restrictive alternative is then to be defined as those procedures which most quickly eliminate the behaviors for which they were designed intrusive only to the point required to achieve clinical effectiveness so that the individual is able to participate more fully in all phases of his/her daily life. Interventions with any degree of restrictiveness must be designed by the ID Team, approved by the individual and his/her representative, the Behavior Management Committee, the Director and the Local Human Rights Committee, and reviewed at least every six months.

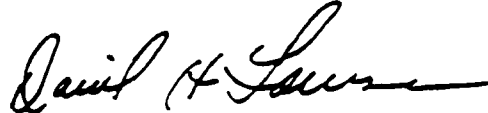
Behavior programs are designed for individual residents taking into consideration not only the above factors but also the individual needs, strengths and developmental/social levels of the clients. Procedural safeguards are also included to ensure that the individual's rights to effective treatment and freedom from undue coercion are balanced and protected.
- V. Procedure.
  - A. Programmatic Uses. Restrictive procedures are one component of a total positive training effort designed by the ID team with the exception of certain

**VTC INSTRUCTION 5300**  
**AGE 2**

emergency situations. See the NVTC Behavior Therapy Procedures Manual for full description of program elements, limitation of use, reviews and documentation necessary for program implementation. A copy of this manual is located with all NVTC psychologists, all Senior Staff members, Program Managers, on all residential units, and the Director, NVTC.

- B. No staff may initiate restrictive procedures except under those conditions specified under Programmatic Uses, and then only when necessary approvals and documentation have been obtained. Violations may be abusive and considered in accordance with DMHMRSAS and NVTC policy on abuse.
- C. Community Programs must contact NVTC in advance to secure the above identified reviews and approvals prior to implementation, per our contractual agreements with them.
- D. Restraints used as Protective Devices. Refer to NVTC Instruction 5301.
- E. Non-Programmatic Uses. Crisis Management (Emergency Procedures): In the event an emergency situation exists where it is likely that a client could harm himself/herself or others and less restrictive procedures are not effective, the client can be physically restrained (MANDT techniques) by any staff member for up to one hour. During that hour if the staff member believes that the physical restraint is ineffective the unit psychologist should be called. If unavailable the on-call psychologist should be contacted with the Chief of Psychological Services; Physician and NVTC Director as back-up. A Crisis Management Form must be completed by the staff and forwarded to the NVTC Risk Manager. If the need for an emergency restraint occurs three times in one year, the need for a more restrictive program will be assessed.

VI. Effective Date. This Instruction will become effective on the date issued.



David H. Lawson, Ph.D.  
Director

DHL:LR/jgf  
Psychology



NORTHERN VIRGINIA TRAINING CENTER  
Fairfax, Virginia

ATTACHMENT

4

September 1, 1994

NVTC INSTRUCTION 5301

TO: Staff

SUBJECT: *Use of Protective Devices*

- I. Purpose. To establish procedures to be followed in authorizing and monitoring the use of "Protective Devices."
- II. Cancellation. NVTC Instruction 5301 dated September 25, 1991 is hereby canceled.
- III. Background. NVTC Variance #V 81-1 to the requirements of Section VI-G of the Rules and Regulations to Assure the Rights of Patients and Residents.
- IV. Definitions:
  - A. Restraints include, but are not limited to any mechanical device such as sheets, towels, straps, helmets, posey vests, IV boards, etc. - that is used to restrict or prevent movement of a client's limbs or body for purposes of providing protection of harm due to over aggressive acts to self or others.
  - B. Protective Devices include, but are not limited to any mechanical device that might ordinarily be used as restraints, defined above. Although devices similar to those used as restraints might be used as a Protective Device, their purposes differ. Protective Devices are used to prevent injury or to enhance functioning or environmental interactions for particular classes of residents, and where required, to promote healing or to enable the delivery of acute medical/surgical treatment.

Protective Devices are those mechanical devices used:

1. For a specific protective/supportive purpose
    - a. to prevent injury, or
    - b. to achieve proper body position, balance or support for those clients with neurological conditions, non-ambulatory clients, or clients with conditions that impair mobility, vision or strength who would otherwise be restricted in their activities and thus be denied stimulation from interactions with others or their environment; or
  2. For acute medical/surgical treatment of clients, where required
    - a. to promote healing, or
    - b. to prevent the interruption of acute medical/surgical treatment, e.g., removing dressings, catheters, IV tubes, nasogastric intubation, etc.
- V. Procedure. The following procedures apply only to the use of Protective Devices as defined in IV. B. Procedures pertaining to Mechanical Devices used as Restraints (IV. A.) are contained in NVTC Instruction 5300. However, should the use of restraints for behavioral purposes overlap with the use of protective devices for medical or other purposes, an individualized program plan shall be developed, approved and implemented in accordance

with specifications in NVTC Instruction 5300. Such programs shall be the joint responsibility of the unit physician and involved psychologist.

**A. Requirements for use of all protective devices:**

1. The use of any protective device on a client shall be ordered and monitored in a manner which is consistent with its specific purpose as outlined in Section IV. B. Unless otherwise stated, physicians are responsible for ordering protective devices and for personally observing the client prior to making initial or renewal orders.
2. Written orders and accompanying individualized plans shall be entered into the involved client's CRS and shall include:
  - a. reasons for use;
  - b. specifications for motion and exercise periods;
  - c. appropriate documentation requirements; and
  - d. instructions for terminating the use of the device as a specific time, if practicable.
3. For clients utilizing protective devices, staff shall assure:
  - a. bathroom privileges are provided according to need; and
  - b. that clients are provided the opportunity to bathe at least every 24 hours.

**B. Additional requirements for devices used for Protective/Supportive Purposes as defined in IV. B., 1.**

1. Following the physician's physical observation of the client:
  - a. For new admissions, or for clients with changes in physical condition, orders must be renewed weekly, for the first month;
  - b. Thereafter, orders must be renewed every 30 days or at the time of any change in the condition of the client.
2. Physical observation by an appropriately trained staff person of the client must be made at least every 30 minutes when the protective device used is one which could cause circulatory problems. Documentation in the client's CRS of the specified observations must be made every eight (8) hours by staff.
3. Specifications for appropriate motion and exercise periods and documentation requirements shall be in accordance with the type and purpose of the device and written in the client's individualized plan.
4. Devices used specifically to achieve proper position, balance or support, including the use of feeding chairs with clients assigned to other than the infirmary, shall be designed and applied:
  - a. under the supervision of a physician, physical therapist or occupational therapist;
  - b. so as to reflect concern for principles of good alignment, concern for circulation and allowances for changed of position.
  - c. Initial application of the device and staff training for ongoing

applications shall be the responsibility of the physical therapist, the physician or the occupational therapist as appropriate.

- d. On a monthly basis, the responsible therapist shall personally observe the resident while he/she is utilizing the device and review those portions of the CRS pertaining to monitoring requirements contained in the client's individualized plan.

5. The use of protective device such as a posey vest ordered specifically to prevent injury from falls during normal sleeping hours shall be prescribed and monitored as follows:

- a. Initial orders shall be written by a physician based upon documented evidence that the use of such a device would prevent further injuries to a client. Orders must be renewed at least every 30 days by a physician's written entry into the client's record.
- b. At the time that changes in condition of the client no longer warrant the use of such device, its use shall be immediately terminated upon order of the prescribing physician.
- c. Opportunity for motion and exercise shall be provided for a period of ten minutes every two hours, however, if the client is asleep, the device need not be released unless he/she is showing discomfort or the device upon visual and physical examination indicates constriction or a loss of circulation.
- d. Physical observation of the client in a sleeping device must be made every 30 minutes and a notation (of ½ hour physical examination of client in the sleeping device), will be entered in the unit bedcheck log and initialed. A monthly I.D. note must be entered in the client's CRS, referencing the log and indicating that physical inspection did occur. The log must be maintained as a permanent record on the unit.
- e. Clients requiring sleeping devices must have rails on their beds. The protective devices are to be tied in such a manner as to allow the client to turn from side to side and to sit up in bed without restrictions.
- f. Nursing staff shall be responsible for demonstrating/ providing training to staff in the application and appropriate monitoring of sleeping devices.

- C. Additional requirements for protective devices used for medical/ surgical purposes as defined in IV. B., 2.

1. If not directly available, after consultation with registered nurse who has personally observed the client, the physician may make the initial order by phone. However, the physician must personally observe the client and renew the order within 24 hours.
2. Thereafter, orders must be renewed after personal observation by the physician weekly or at the time of any change in the condition of the client.
3. Physical observation of the client by appropriately trained staff must be made every 30 minutes and documented in the client's CRS each eight (8) hours.
4. Opportunity for motion and exercise periods shall be provided for a period of not less than 10 minutes each 2 hours in which a protective device is used

unless the client is asleep (see Section V. B. 5. c. for requirements pertaining to protective devices used during sleep). Such motion and exercise periods shall be documented as occurring or not occurring. If the latter supplies, reasons shall be noted.

5. If a protective device is to be utilized for a period exceeding one week, the Director, NVTC, and the Advocate will be notified by the Director of Health Services. Action on the part of either will be contingent on review of available information relating to the client's status or condition.

D. Uses of feeding chairs and routine night-time bedside rails.

1. The use of feeding chairs during mealtimes, except when utilized in conjunction with plans authorized by a physical therapist or occupational therapist as stated in Section V. B. 5, and/or use of routine night-time bedside rails shall be prescribed and monitored in accordance with standard nursing procedures.
2. Orders may only be written after physical observation by an RN or Physician and must be renewed monthly.

VI. Effective Date This Instruction will become effective on the date issued.

  
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Director

DHL:LR/jgf  
Advocate

# **BEHAVIOR THERAPY PROCEDURES:**

**Philosophy of Use, Definition, and  
Staff Responsibilities**

Psychological Services  
Northern Virginia Training Center  
9901 Braddock Road  
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September 1, 1993

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## NORTHERN VIRGINIA TRAINING CENTER

### BEHAVIOR THERAPY PROCEDURES: PHILOSOPHY OF USE, DEFINITION AND STAFF RESPONSIBILITIES

#### I. PHILOSOPHY

The Northern Virginia Training Center (NVTC) is dedicated to the principle that all individuals are entitled to develop to their fullest potential and become as independent as their innate capability will permit. (See Appendix A for Missions and Goals of NVTC.) Individuals of all ages and sex with developmental disabilities, regardless of the nature and degree of their cognitive, emotional, behavioral, or physical disability, are capable of learning and will benefit from the successful application of current behavioral technologies.

The Mandt System of behavioral interaction has been adopted by the commonwealth of Virginia and accurately reflects the treatment philosophy of NVTC. This system not only provides the underlying foundation for all behavioral interactions with the clients but is also viewed as an integral component of all formalized behavioral management programs. All staff are trained in the use of the Mandt System and are expected to integrate the application of nonphysical and physical methods of interaction with formalized restrictive and nonrestrictive behavioral programs. (See Appendix K for an outline, i.e., table of content, of the Mandt System.)

The policy and philosophy of NVTC is to (a) focus on equipping all clients to communicate their needs and desires, providing models of adaptive and socially acceptable behavior, and providing environments and experiences that are reinforcing, and (b) seek the least restrictive programming alternative for each client, i.e., there must be a match between the nature and severity of the problem and restrictiveness/intrusiveness of the procedure, and (c) ensure the protection of each individual's rights when restrictive procedures are utilized. The least restrictive alternative is to be defined as those procedures which will most quickly eliminate the behaviors for which they were intended, intrusive only to the point required to achieve clinical effectiveness, so that the individual is then able to participate more fully in all phases of his/her daily schedule of training programs.

Behavior Therapy Programs are based on the premise that adaptive and maladaptive behaviors are learned behaviors, and

hence can be modified through the systematic application of principles of learning. These programs are developed with the participation of individuals served and their parents, guardians, or advocates, are designed for individual clients taking into consideration not only the above factors but also the individual needs, strengths and developmental/social levels of the client. Procedural safeguards included in this document are designed to ensure that the individual's rights to effective habilitation and freedom from undue coercion are balanced and protected.

The purpose of this Behavior Therapy Procedures manual is to provide policy and procedural guidelines for the design, development, and implementation of treatment programs for individuals with specific behavioral training needs. It is our expectation that services delivered through quality behavioral programs will enhance the maturation, development, well-being, and quality of life of all NVTC clients within the most normal and least restrictive environment consistent with their needs.



## II. DESIGN OF BEHAVIOR THERAPY PROGRAMS

Behavioral therapy programs at NVTC are based on the model of "Behavioral Deficits/Behavioral Excesses." Therefore, the individualized habilitation plan for a client who exhibits maladaptive behavior includes provisions to teach the individual the circumstances, if any, under which the behavior can be exhibited adaptively, to teach the individual how to channel the behavior into similar adaptive expressions, or to replace the maladaptive behavior with behavior that is adaptive. Reliance on reactive control procedures is unacceptable.

Individuals' behaviors are reviewed and analyzed to determine potential causes of maladaptive behaviors that may be related to factors in the individual's life, such as (a) lack of exposure to positive models and teaching strategies, (b) lack of ability to communicate needs and desires, (c) lack of success experiences, (d) lack of social, community, and leisure skills, (e) insufficient quantity of high quality activities at an appropriate level, (f) lack of opportunities to interact with others, (g) history of inappropriate reinforcement and punishing experiences, (h) inadequate coping skills to deal with frustration, stress, and anger, (i) boredom and environmental stresses, (j) a physiological condition, e.g., pain, discomfort, and low sensory threshold such that maladaptive behavior occurs when the threshold is breached, or (k) psychiatric conditions.

Behavior management programs are designed to reduce or eliminate behaviors which interfere with ongoing training, and to teach the client more socially acceptable behaviors. Behavior programs provides a high degree of consistency by identifying the targeted behaviors and specifying what the staff response should be. Behavior programs generally consist of two main components. The first is a set of training procedures teach clients alternative replacement behaviors which serve the same function (purpose) as the maladaptive behaviors. For example, teaching a client to get attention by knocking on the team station door rather than engaging in self-injury. The second is a reactive procedure to manage the maladaptive behavior when it occurs. This may consist of procedures ranging from verbal prompts to "calm down" to the application of highly restrictive mechanical restraints.

Several essential program development components must be addressed before a comprehensive and effective behavioral programs can be designed. These basic components, as described below, must be taken into consideration regardless

of the individuals adaptive behavior training needs, severity or nature of targeted maladaptive behaviors, or degree of program restrictiveness. See also Section III.

- A. Socially appropriate behaviors which are currently available and displayed by the client must be identified. Additional training may be needed to strengthen these behaviors or develop new behaviors as replacements for inappropriate and maladaptive behaviors.
- B. Targeted maladaptive behaviors must be clearly defined and described in detail (e.g., operational definitions) to enable staff to accurately record their frequency, intensity, duration, and other significant behavioral characteristics. There are several categories of information which should be collected as a part of baseline data. These, in addition to the behaviors themselves, include: (a) antecedents - what happened or what conditions existed just before the maladaptive behavior occurred; (b) consequence - what happened to the antecedent conditions as a result of the maladaptive behavior; (c) client's response - how did the client responded to the consequence; and (d) ecological or environmental conditions - where the behavior occurred, time, date, persons present, noise level, etc.

Baseline data are then collected over a specified period of time without any intervention in order to (a) provide information in determining the function or purpose of the behavior, i.e., why the client engages in the behavior, and (b) determine the effectiveness of the treatment procedure (behavior program) by comparing baseline data to treatment data.

Collection of baseline data can take a variety of different forms depending upon the type and rate of behavior. Generally, low severity behaviors, such as tantrums can be observed over an extended period of time with minimal interventions whereas severe self-injurious behaviors cannot be unattended for any length of time. Also, low frequency maladaptive behaviors may require an extend period to time to observe these behaviors in sufficient frequency to establish a pre-treatment rate of occurrence. On the other hand, high frequency behaviors may be sampled or probed during specific time periods, e.g., collecting data for an hour each day for a week.

- C. An assessment of the client's motivational bases for the targeted maladaptive behavior(s) is conducted by the psychologist through record reviews, direct observations of the client, and with input from other members of the client's Interdisciplinary Team. This procedure may

include, but not limited to, the following forms of assessments: structural, functional, and analog. (For a more detailed description of the assessment procedure and an example of the worksheet used in this process, please refer to Appendix D.)

- D. Once the behavioral assessment has been completed, the psychologist continues his/her leadership role in the design and development of a comprehensive behavioral program. Among the issues to be addressed are:
1. Ecology. The relative significance of the environment on the client's behavior, i.e., an analysis of the conflicting needs of the client versus constraints, limitations, and/or conditions in the client's physical and social environment which contributes to the occurrence of maladaptive behaviors. Wherever possible, ecological factors should be adjusted to meet the needs of the targeted client without impinging on the needs and rights of other clients.
  2. Total habilitation program. The interactive nature between and among habilitation programs and behavior requires an analysis of the clients total habilitation program. Therefore, the relative contribution of such programs as speech, recreation, and occupational therapy must be recognized along with the need to ensure coordination of all habilitation programs.
  3. Behavioral program. Development of a comprehensive behavioral program which address the identified training needs of the client through positive reinforcement procedures. When applicable, the program will also describe the least intrusive intervention procedure to deal with maladaptive behaviors related to clients' health and safety.
- E. Priority target behavior(s) will be identified by the psychologist for behavioral intervention. The primary concerns which must be addressed when selecting the targeted behavior(s) for programmatic intervention are:
1. Which behavior or category of behaviors is most disruptive to the client?
  2. Will modification of the behavior(s) enable the client to adapt more effectively to his/her environment?

3. Are resources available to effectively address the targeted behavior(s)?
  4. How can the occurrence of the behavior be recorded reliably?
- F. The psychologist will then generate hypotheses regarding the causes of the maladaptive behavior(s) and procedures will be identified and included in the program to increase the probability of socially appropriate forms of the behavior(s) necessary to accomplish the same inferred ends. These procedures may take the form of:
1. Specific training sessions to teach the appropriate behavior(s), especially if they are not already in the client's repertoire;
  2. a positive reinforcement program "overlay" of the client's daily activity schedule as an integral component of ALL behavioral programs;
  3. procedure(s) which addresses the health and safety needs of the client and others; or
  4. a combination of the above, whichever is deemed clinically appropriate.
- G. Although not entirely under psychological purview, any behavior therapy programs must pay special attention to the client's daily activity schedule. Too much structure (i.e., too many activities) may contribute to the maladaptive behavior(s) while too little structure (i.e., too few activities) may, likewise, contribute to the maladaptive behavior(s). A functional analysis, as noted earlier, may indicate that the same behavior can serve different functions in different situations as well as for different clients and that specific activity components within the daily activity schedule may need examination as they, too, may be contributing to maladaptive behaviors.
- H. The design, development, and implementation of activities within the context of the client's daily routine is the responsibility of all disciplines working together as a team. These activities should directly address the individual training needs of the clients but may also be used as carriers for other forms of training. For example, communication, leisure, and recreational skills training can serve as ends in themselves but they can also be used to encourage and promote the display of more appropriate forms of behavior in a wide variety of social situations.

Planned monitoring of the clients' behavior must also be conducted on a regular basis. This may take the form of assessing the interaction patterns between staff and clients as well as the behavior of the clients themselves. Psychological Services currently uses the GATOMF (Group Active Treatment Outcome Monitoring Form) developed by Reid & Parsons (1990) to document the extent to which clients are engaged in activities which have varying degrees of therapeutic utility from an active treatment perspective (See Appendix I). This information is then provided to residential unit supervisors to enable them to provide the clients with the most therapeutic environment.

- I. The psychologist also recognizes that contextual influences also shape the emergence and display of maladaptive behaviors. Environmental factors, such as temperature and climatic conditions, over-crowding, activity and noise levels, social interaction patterns between and among staff and clients, and task demands contribute to the development of the client's behavioral topography. In particular, the communicative intent of maladaptive behavior(s) must be recognized and addressed in a comprehensive habilitation program developed by the psychologist, speech therapist, and/or other significant member of the client's Interdisciplinary Team.
- J. An effective behavior therapy program must also consider the impact of intrinsic and extrinsic factors on the development and maintenance of maladaptive behaviors. For example, the dietitian, physician, and other medical practitioners should be consulted to determine the significance of the client's diet, allergies, and other physiological conditions which may be contributing to the maladaptive behavior(s).

The psychiatrist should also be consulted if there are any suggestions that mental health issues may be involved. If psychotropic medications are prescribed as an adjunct to the client's behavioral program, then the effects of the medications on the client's behavior (i.e., psychiatric features such as hallucinations, delusions, hyperactivity, lethargy, sleeplessness, etc.) will be monitored on a regular basis. (See Appendix J for an example of one monitoring instrument.)

Therefore, the policy of NVTC is to focus on (1) the establishment of the most therapeutic social and physical environment possible within residential programs participating in Title XIX Medicaid Program for Intermediate Care Facilities for individuals with Mental Retardation (ICF/MR), such as

NVTC, (2) the provision of habilitative services, i.e., individualized and integrated training which constitutes what is considered to be active treatment, and (3) the promotion and use of positive training techniques to increase the probability of occurrence of appropriate behavior(s) for the client, while at the same time, enabling the client to achieve the same inferred motivational ends. This entails teaching the client to make discriminations of which behaviors are acceptable or unacceptable as well as when and where certain behavior(s) is/are appropriate. For example, jumping on furniture on the residential unit may be dangerous to the client and is destructive of property; jumping on appropriate recreational equipment may be safer for the client, less destructive of property, and, hopefully, more enjoyable.

### III. BEHAVIOR THERAPY PROGRAMS: ADAPTIVE BEHAVIORS THROUGH POSITIVE PROCEDURES

Behavioral programs are developed for the purpose of teaching clients alternative replacement behaviors which serve the same function or purpose as their maladaptive behaviors. These behavior programs must be designed to increase individuals' repertoire of adaptive and socially appropriate behaviors to increase their independence and eventual re-integration into their communities.

A variety of training procedures grounded in the principles of learning are currently available to assist the clients to develop more socially acceptable behaviors, thereby reducing the occurrence of maladaptive behaviors. The basic underlying assumptions of behavior therapy programs are: (a) behavior problems are learned, (b) behavior problems are learned separately, (c) behavior problems can be modified using the principles of learning, (d) the behavior problem that a client exhibits in a particular situation indicates only how that individual behaves in that specific situation, (e) emphasis is placed on treating the client's behavior in the here and now, (f) goals and objectives of behavior management programs are specific, and (g) symptom substitution does not occur if there has been an accurate identification and modification of those factors contribute to the client's behavior problem.

A variety of behavioral and nonbehavioral (i.e., environmental manipulations) management procedures are available for use with the clients of NVTC. These include, but are not limited to the following:

- A. All clients should participate in on-going planned activities which are implemented as part of their daily activity schedule. Individuals who are engaged in activities, particularly activities they enjoy, are less likely to display inappropriate, disruptive, and other forms of maladaptive behaviors. These activities, such as unit-based and structured recreation and leisure, speech and language training, and vocational skill training, also serve as excellent carriers or vehicles for individualized and group training. Adaptive and targeted replacement behaviors which can be addressed during these activities include such behaviors as cooperation, communication, compliance, social interaction, and skill acquisition.
- B. Positive reinforcement systems: The presentation of a stimulus (e.g., an activity or commodity), the emission

of an adaptive behavior (or the absence of a maladaptive behavior), and the application of a reward serves to increase the reoccurrence probability of that behavior. If the targeted behavior increase in frequency (or other measure of improved behavior) as a result of regularly scheduled data probes, then it is highly probable that the contingent stimulus is reinforcing for the individual. This form of response-reinforcement is the most common and most effective method of developing, strengthening, and increasing the display of adaptive replacement behaviors.

Since it is not uncommon for an individual to have more than one targeted behavior which needs to be changed, the behavior that should be changed first is the one that is judged to be easiest to strengthen. For a variety of reasons, including generalization, increased self-image because the client begins to experience success, increased numbers of positive staff-client interaction patterns, the success of this response-reinforcement contingency procedure will then make it easier to strengthen and/or develop other adaptive behaviors.

1. Differential Reinforcement of Appropriate Behaviors (DRA): A basic procedure in which rewards are contingently given for displays of targeted appropriate behavior(s).
2. Differential Reinforcement of Other Behaviors (DRO): A procedure in which a reinforcement is delivered at the end of a specified time interval if the client is engaged in any response other than the targeted maladaptive behavior.
3. Differential Reinforcement of Incompatible Behaviors (DRI): A procedure in which a reinforcement is delivered if a specified adaptive behavior occurs that is topographically incompatible with the targeted maladaptive behavior.
4. Differential Reinforcement of Low Rates of Behavior (DRL): A procedure in which reinforcement is delivered only if (a) a specified period of time has elapsed since the last maladaptive response has occurred, or (b) fewer than a specified number of the targeted maladaptive behavior has occurred during the preceding time interval.
5. Response Cost: Response cost generally involves a token economy system but can be used when any reward is given for displays of targeted adaptive behaviors. The basic concept is that an individual



loses a reward, e.g., a token(s) or other desirable item(s), whenever an unacceptable behavior is displayed. Response cost does not involve contingent personal property removal or the restriction of privileges.

- C. Schedules of rewards: Even if it is possible to reward an individual for each desirable behavior, research has indicated that this procedure may not be the most effective in maintaining the learned behavior. In most cases in which rewards have been given continuously, the behavior rapidly decreases if the rewards are removed. This will not occur if, after the individual has learned the targeted behavior, rewards are given on an intermittent or partial basis instead of a continuous basis.

Among the four basic reward schedules presented below, the two most widely used schedules with severely handicapped individuals are the Fixed Ratio and Variable Ratio schedules.

1. Fixed Ratio (FR) reward schedule: The individual receives a reward only after he has exhibited a fixed number of the targeted behavior.
2. Variable Ratio (VR) reward schedule: Similar to the FR schedule except the individual does not always receive the reward after a fixed number of correct responses. A VR-3, for example, means that the individual receives a reward on the average after every 3 correct responses.
3. Fixed Interval (FI) reward schedule: The individual receives a reward only after exhibiting the targeted behavior after a fixed interval of time has passed.
4. Variable Interval (VI) reward schedule: Similar to the FI schedule except the individual does not always receive the reward after the same fixed interval. Rather, the individual is rewarded on a variable time interval schedule which is randomly determined. For example, VI-3 means that an individual is rewarded on the average of every 3 minutes following the first correct response.

D. Factors which influence the effectiveness of rewards.

1. Immediacy of the reward: The greater the immediacy of the reward following a targeted behavior, the greater the effectiveness of the reward. If the behavior cannot be immediately rewarded, a "bridging

- cue" should be used. For example, staff should say or do something to bridge the time delay between the behavior and the reward.
2. Consistently rewarding behavior: During the initial stage of response development, all staff should consistently reinforce all targeted behaviors. Once the behavior is well established, the "reinforcement schedule" should be changed to a variable procedure in which a reward does not always follow the occurrence of the targeted behaviors.
  3. Combining praise with the tangible reward: Never give a tangible reward without praise, unless it is obvious that the individual does not like to be commended. As a general rule, nontangible rewards associated with a staff member (e.g., an approving look, verbal praise, pat on the back, etc.) are preferred over more concrete rewards, e.g., drinks and food items.
  4. Schedule of reward: The contingency between a behavior and a reward is learned more easily when training begins at a low level FR schedule. As the behavior becomes more firmly established, the schedule can be changed to increase response persistence and generalization.
  5. Type of tangible reward. Determine what is most desirable for the individual, e.g., use a reward menu, and begin each session after determining what appears to be most effective at that time. More than one type of reward may need to be used during any given session.
  6. Quality and quantity of reward. Be sure to use fresh and desirable tangible rewards and deliver all rewards with sincerity and enthusiasm. Give edibles and liquid rewards in small amounts while other forms of rewards, such as activity and physical contact, should be given for correspondingly short periods of time.
  7. Individual who gives the reward. The reward should initially be given by someone who is a meaningful figure in the individual's life. After the contingency between the client's response and the resulting reward is established, encourage stimulus (i.e., staff) generalization by assigning other staff members as reward dispensers.

E. Symbolic reward systems: Any item, person, or event can take on reinforcing properties when it is consistently associated with a reward. The following are examples of commonly used symbolic systems.

1. Token Economy System: This is an "economy system" since it is based on a "normal" monetary system. However, instead of receiving a dollar or some other monetary amount, an individual receives a token. A token must (a) be something a person can see, touch, and count; (b) be in a specific place to see how many is earned; (c) be exchangeable for actual rewards; (d) be obtainable from more than a designated person(s) dispensing the tokens; and (e) be contingent upon the display or absence of specific behaviors.

Response Cost: Once a token economy is well established, a procedure can be used for placing a price on the display of undesirable behavior(s). (See description under "Positive Reinforcement Systems.")

2. Star charts: A highly visible behavior charting mechanism in which the occurrence of targeted behaviors (usually adaptive behaviors or the absence of maladaptive behaviors) are high-lighted with a symbol, e.g., with a "star," "happy-face," etc., on a fixed interval schedule. After a specified number of symbols are accumulated, they are then exchanged for a reward.
3. Other positive symbols: Any items which can be worn and displayed by an individual can serve as a reward. For example, a necklace, bracelet (wrist bands, wristwatch, etc.), or badge (ribbon, button, etc.) can be given to an individual whenever adaptive behaviors are exhibited. The recipient not only "knows" what the symbol represents but, because the symbol is worn by the individual, staff and significant others can draw attention to the symbol and provide additional rewards in the form of praise, attention, and social interaction.
4. Level system: Access to selected activities can also be used to discourage the display of maladaptive behaviors. For example, a client will begin on the lowest level and will be permitted to participate in a limited number of activities, e.g., residential unit activities only. When he does not display any of the targeted maladaptive behaviors for a specified period of time, he is moved to the

next level where he now has access to a greater variety and number of activities, e.g., off-unit but only on-grounds activities. The third level can be supervised off-grounds activities, e.g., selected community-based activities.

- F. Techniques of training (behavior shaping) include, but are not limited to the following hierarchy of prompts. Compliance with each prompts should be appropriately reinforced. The goal is to make the client as self-sufficient and independent as possible, i.e., self-initiation of tasks and activities with no or minimal prompting.

1. Verbal Prompting - Lowest level of prompting in which verbal cues are used to describe and promote the occurrence of the targeted adaptive behavior; may also include manual/sign communication.
2. Gestural Prompting (Modeling) - Showing the client the response to be learned through modeling or imitation.
3. Shadowing - Following the client's movements through the desired response with staff's hands in order to use higher levels of prompting if necessary.
4. Physical Prompting - Gently touching the client to initiate and/or continue the response in a correct manner.
5. Physical Guidance - Physically directing a resistive client through the entire response sequence. If physical guidance is used for more than 1 minute, then the procedure is considered to be restrictive and requires the approval of the Behavior Management Committee (BMC), Local Human Rights Committee (LHRC), etc. (See Appendices B and C, respectively, for descriptions of their goals and functions.) Attempts should be made to decrease the degree of physical involvement whenever possible.

- G. Training procedures for relatively complex behaviors:

1. Successive approximation: An individual should be taught a "complex" activity in successive steps - with each step gradually leading to an approximation of the desired target behavior. For example, instead of teaching a person the whole behavior of putting on a pair of pants, this complex behavior would be broken down into its component parts. Each part would then be taught separately such that one

component is then chained to the next component until the whole behavior is performed satisfactorily.

2. Behavioral chaining: The linking of behavioral components until a complex behavior is learned according to a predetermined sequence. For example, brushing teeth can be broken down into a number of isolated behaviors which are taught separately (e.g., pick up toothbrush, put paste on the brush, insert toothbrush into mouth, etc.) and then combined into the desired behavior.
  - a. Reverse training: Linking of behavioral components in a reverse manner, i.e., the terminal component is taught first and then systematically linking each component to the preceding component in a stepwise fashion until the whole behavior can be performed without interruption from beginning to end.
  - b. Forward training: Opposite of reverse training, i.e., teaching a whole behavior by linking the first component with the second, the second with the third, until all the components are linked together to form the desired behavior.

#### H. Other behavior training procedures:

1. Re-direction to another activity: When a client begins to engage in a maladaptive behavior, staff will intervene to determine probable causes and eliminate or reduce the effects of the disruptive influences. Staff will then attempt to encourage the client to either return to the required task or activity, or to engage in another form of appropriate behavior. As a rule, redirection is more successful if the suggested activity is easy to perform and enjoyable to the client. This is not an appropriate procedure if the redirection becomes a reinforcer for the inappropriate behavior. Redirection should be recognized to be a temporary measure in that the problem or reason for the maladaptive behaviors has not been directly addressed.
2. Stimulus Control: A technique in which a maladaptive behavior (i.e., typically used for stereotypical and perseverative behaviors and not a serious behaviors) is brought under control by pairing it with a particular stimulus under the

control of staff. Once the behavior is linked with a controlling stimulus, that stimulus can then be systematically reduced to decrease the occurrence of the maladaptive behavior. Variations of this procedure include instructional control.

3. **Extinction:** A procedure in which positive reinforcement is withheld following a maladaptive behavior. For example, a maladaptive behavior that disrupts normal and routine interactions between staff and clients can be addressed through active ignoring, i.e., staff does not attend to or recognize the occurrence or existence of the emitted behavior. The exception is when blocking or redirection is needed for momentary stopping the maladaptive behavior if the intensity of the episode endangers the client or staff. The success of this procedure depends on the extreme consistency of withholding positive reinforcement whenever the targeted behavior is displayed (otherwise, a partial reinforcement schedule is inadvertently being used to maintain the undesirable behavior).
4. **Satiation:** A procedure which is generally viewed as antithetical to extinction. Satiation involves the giving of unlimited access to positive reinforcement which is believed to be maintaining a targeted maladaptive behavior. For example, if a client hoards or steals clothing from other clients, then the client would be given unlimited/excessive amounts of clothing with the expectation that he/she would lose interest in the items.
5. **Modeling (or imitative learning):** A procedure in which the desired behavior is first demonstrated to the individual and then rewarding the individual for successfully imitating the modeled behavior (generally accomplished through the techniques of shaping, e.g., successive approximation). Staff must be sure that the individual is highly imitative and that the person who performs the modeled behavior is relatively attractive and/or prestigious to the individual.
6. **Individual counseling:** The general orientation is to focus on concrete and specific behaviors commonly expected in certain situations, e.g., what would normally be expected as a "socially appropriate behavior" in a specific situation. Psychodynamic parameters, such as attitude, expectations, affect, etc. may also be incorporated into the counseling session when deemed appropriate (i.e., based on the

intended outcome of the sessions, functioning level of the individual, etc.). Individual or group counseling sessions may also be more effective if they are given a sense of importance to both staff and client by prescheduling as to time and place, and, in some cases where attending and/or participating themselves are issues, rewards, tokens, and other forms of incentives may also be incorporated the clients' programs.

7. **Behavioral contracts:** A written contractual agreement between a client and staff in which the occurrence of a targeted behavior will result in a reinforcing conditioning, e.g., a client agrees to allow staff to inspect his closet for stolen soiled clothing in exchange for the privilege to lock his closet. Included in this contract are such items as the identification of specific behaviors to be targeted, staff and client expectations, consequences of targeted maladaptive behavior, and performance criteria leading to the fulfillment of the contract.

I. **Training in skill acquisition.** The behavioral repertoire of many mentally retarded individuals is relatively limited and does not permit them to adequately express their wants and needs. Therefore, behavioral outlets often include inappropriate, disruptive, and aggressive forms of behavior as well as more socially acceptable forms of expression. Areas for continued training include, but are not limited to the following:

1. **Communication skills training:** When maladaptive behaviors have been determined to serve a communicative function, the client's habilitation plan, as developed by the Speech/Language Therapist and other key members of the Interdisciplinary Team, must include plans to teach the client other means of communication, thereby significantly reducing the function of the maladaptive behavior.
2. **Community, social, and leisure skills training:** Because clients will engage in both acceptable and unacceptable behaviors to occupy their time, they must be engaged in training programs which will increase their interests and competencies in activities other than those which focus on self-care and vocational needs. The Recreation Therapist, Speech Pathologist, Occupational Therapist, and other clinical and residential staff members of the Interdisciplinary Team, must be involved in these programming areas.

3. Self and/or anger management training: Efforts should be directed to the training of self management techniques to enable the clients to deal with their frustrations, anger, and other negative affect in more socially appropriate ways. Examples of such procedures include progressive relaxation training and individual/group counseling sessions on techniques of affective management.

J. As such, a behavior therapy program may consist of entirely positive components to shape and teach more socially acceptable forms of behavior(s). However, it must be recognized that staff must also be trained in how to consistently respond to any display of maladaptive behaviors.

Training may occur within highly structured sessions or within the context of the client's daily routine. The latter procedure is generally the preferred approach since it is less artificial or contrived and its greater generalizability to the client's normal life.



#### IV. BEHAVIOR THERAPY PROGRAMS: ADAPTIVE BEHAVIOR TRAINING AND RESTRICTIVE PROCEDURES

In order to address a client's behavioral needs, it may be necessary to use positive procedures as previously described in conjunction with either limit-setting, nonrestrictive behavioral procedures, or more intrusive and restrictive behavioral procedures. Again, the philosophy and policy of NVTC is to emphasize the positive features rather than the reactive aspects such as limit setting, nonrestrictive, or restrictive procedures which comprise only one small part of the client's overall behavior therapy program. Several points are significant and should be to be addressed within this context.

A. Limit-setting procedure may serve a variety of functions.

1. Limit-setting procedures serve to interrupt a chain of behavior(s) before they escalate to more intense forms of behavior. As such, they may be keyed to a clinical knowledge of the client's "typical" behavioral sequence (i.e., chain).
2. By intervening earlier in the response chain, more intrusive and restrictive behavioral management procedures may not be necessary.
3. Likewise, low levels of maladaptive behavior(s) may be amenable to redirection and limit-setting procedures without having to resort to more intrusive or restrictive intervention strategies.

B. Generally, restrictive procedures are defined as any procedure which:

1. Restricts a client's freedom of movement.
2. Limits access to activities, objects, or events to which a client would otherwise be entitled as a part of his/her rights.
3. Causes a resistive client to perform a specific behavior.
4. Results in altered states of consciousness, i.e., change in the psyche due to the administration of psychotropic medication.

C. It is along the lines of perceived restrictiveness of various behavioral intervention procedures that levels

were established. Guidelines in establishing these levels of restrictiveness are:

1. The procedure itself. Some procedures are, by their very nature, more restrictive/intrusive than others. For example, verbal redirection into a room to calm an aggressive client is less restrictive than the use of a personal restraint to achieve the same end.
  2. The duration of the prescribed procedures. With the same procedures, in many but not all cases, shorter durations were designated as less restrictive than longer durations.
  3. The degree to which physical intervention is required to implement the procedure. Some procedures offer the possibility of their being implemented through verbal control by staff with no physical interventions required. These procedures, under verbal control, are designated as less restrictive than the same procedures requiring physical implementation.
- D. It is the position of NVTC that the following procedures are not used to address maladaptive behaviors:
1. Corporal punishment is not employed.
  2. Seclusion, defined as noncontingently placing an individual alone in a room or another area from which egress is prevented, is not employed.
  3. Individuals are not placed in totally enclosed cribs or barred enclosures (other than cribs).
  4. "Papoose boards" are not used as a form of mechanical restraint.
  5. Individuals served do not discipline other individuals served.

Throughout the instruction, the greater the perceived restrictiveness of the procedure, the higher the levels of consent and approval required prior to program implementation in order to protect the above-mentioned interests of the client. Nonrestrictive programs require the approvals of the IDT and psychologist (and occasionally the physician and dietitian) while restrictive procedures require the same approvals with the addition of: parent/guardian, BMC (see Appendix B), LHRC (see Appendix C), and NVTC Director. The Client Advocate is informed of all restrictive behavioral programs.

## V. DESIGN AND IMPLEMENTATION OF BEHAVIOR PROGRAMS

Behavioral programs have been demonstrated to be relatively effective in addressing a wide variety of behavioral needs, ranging from the development and refinement of adaptive and community living skills training to the reduction and elimination of highly disruptive and aggressive outbursts. All treatment programs are designed to use behavioral management procedures which are clinically sound and are the least restrictive and intrusive procedures necessary to bring about behavioral change.

- A. Formalized Behavioral Programs - Behavioral management procedures may be implemented either with or without a formal written plan of training and intervention. In some situations the psychologist and IDT will determine that the identified behaviors do not necessitate a formal written program and can be addressed through the use of routine behavioral management practices, such as those taught in pre-service and in Mandt System training.

Formal behavioral programs are developed in various ways, depending upon their need for immediate implementation and degree of restrictiveness. Formal behavioral programs cannot be implemented without prior approvals.

1. A behavioral program using only nonrestrictive procedures requires the approval of the Psychologist and the Interdisciplinary Team. However, other approvals may also be required, depending upon the purpose, methodology, and outcome of the treatment program. For example, if edible reinforcers are part of the program, then advice and approvals of the dietitian and physician should be secured. (See Section VI: Summary of Programmatic uses of Restrictive Procedures.)
2. A behavioral program using restrictive procedures requires the approval of the Psychologist, Interdisciplinary Team, Physician, Parent/Guardian, Behavior Management Committee, Local Human Rights Committee, and NVTC Director. The Human Rights Advocate is also sent a copy of the program. (See Section VI.)
3. In some situation when a restrictive program must be implemented prior to the next scheduled meeting of the BMC, a behavior program can be presented for Interim approval after the approvals of the IDT and

authorized representatives are obtained. The BMC chair can approve the program for a time period not to exceed the next regularly scheduled meeting. As outlined in the DMHRSAS Rules and Regulations to Assure the Rights of Residents, "interim program" requires the approval of the Psychologist, Authorized representative (Parent/Guardian), IDT, BMC, and LHRC. Interim approval can be given for all procedures except for Time-Out.

4. Emergency approval for specific treatment procedures may be obtained for 72 hours for matters of immediate health and safety for the client and less restrictive alternatives have been determined to be unfeasible. This is generally a medical concern and requires the approval of either the Physician or Psychiatrist and a written medical order. For example, a mechanical restraint may be ordered to protect a client from serious injury as a result of a sudden appearance of self-mutilation behavior.
5. Approvals for clinical trials must also be obtained when restrictive procedures are under evaluation. On a short-term basis only, not to exceed 2 weeks, the psychologist may, for diagnostic purposes, implement any procedure up to but not including time-out or aversive stimulation as a consequence of targeted maladaptive behavior(s). Approvals required are the same as those for an interim program.

Immediately following such implementation, the psychologist will enter an ID note in the client's CRS specifying the behavior(s) the client was exhibiting, the procedure used, date, time, duration of the procedure, client's reaction to the procedure, and other staff who had assisted.

- B. Programmatic Use - Restrictive procedures at NVTC cannot exist by themselves except in emergency situations (i.e., Non-Programmatic Uses). The use of these procedures programmatically must be done in the context of an overall planned behavior management program as designated by the Interdisciplinary Team.

Restrictive procedures, when used programmatically, are designed to be used after efforts to use nonrestrictive procedures have been unsuccessful or deemed inappropriate by the functional analysis. However, all restrictive programs are generally designed to use less restrictive procedures as the initial reaction to a behavioral issue.

This is based on the assumption and expectation that the client will (1) eventually learn to appropriately respond to early and nonphysical/nonrestrictive forms of behavioral interaction resulting in the termination of the behavioral episode, (2) learn to respond in such a manner that restrictive procedures will be used less frequently as training progresses, and (3) no longer need restrictive interaction procedures to manage maladaptive behaviors in the future.

For example, if a time out procedure is indicated by the functional analysis (e.g., the client becomes disruptive or aggressive to get staff's attention), the behavioral program should incorporate the use of less restrictive procedures as the first step, such as problem-solving, redirection to preferred activities, limit-setting, or redirection to a quiet area, before the restrictive procedure of time out is used.

Behavioral programs, using both nonrestrictive and restrictive procedures (which incorporates nonphysical and physical interaction procedures described by the Mandt System) may be viewed as a relatively temporary "over-lay" of the client's daily activity schedule.

1. Restrictive procedures may be used only when the individual's behavior:
  - a. Presents a danger to self, others, property, or is severely disruptive to a therapeutic environment; and/or
  - b. Interferes significantly with the individual's developmental/social progress.
2. Programmatically, restrictive procedures may be used only:
  - a. As part of a planned, approved, and documented habilitation program designed by the psychologist and Interdisciplinary Team that emphasizes the use of positive techniques of behavior management and the development of appropriate replacement behaviors.
  - b. When other less restrictive alternative procedures have been (a) consistently implemented and documented as unsuccessful, or (b) treatment literature or clinical judgment indicates that the proposed intervention

represents the least restrictive alternative appropriate to resolve the problematic behaviors(s).

- c. When they are designed to lead to less restrictive ways of managing and/or ultimately eliminating the behavior(s) for which they were employed and subsequently eliminating the necessity of restrictive components of treatment programs.
3. Restrictive procedures may not be used (a) in the absence of maladaptive behaviors, (b) in retribution, (c) for staff convenience, (d) as a consequence of insufficient staff, (e) in the absence of positive habilitative programming, or (f) as a substitute for behavioral programming. Except for valid emergency situations as specified in the NonProgrammatic Sections, restrictive procedures may not be used with clients until individualized plans have been developed, reviewed, and approved as specified in this instruction. To subject a client to these procedures may be considered abusive and reviewed in accordance with NVTC Instruction 5002, "Abuse or Neglect of Resident".
4. No restrictive procedure with the exception of mechanical restraint used as a response prevention device may be used during "down time". Down time is to be defined as periods of time greater than 15 minutes during which the client is not under visual but only under auditory supervision and/or staff are not immediately available. This is to be distinguished from true "leisure time" in which staff are directly available to the client and are offering options of activities from which the client may choose. During periods of "down time", if the client begins to exhibit maladaptive behaviors, staff are to utilize the sequence of procedures described in Section V.D.3., (Crisis Prevention and Intervention Procedures).
5. When a client exhibits maladaptive behavior and systematic efforts to eliminate the behavior have been demonstrated to be ineffective, the need for the services of a behavioral management consultant will be recommended to the Interdisciplinary Team by the psychologist.
6. In the design, development, and implementation of a behavior program, the psychologist is responsible for:

- a. Involving the participation of members of the client's Interdisciplinary Team which includes personnel from the client's residential unit, clinical support staff, day placement (e.g., school, workshop, etc.), the client and his/her parents, guardian, or advocate.
- b. The clinical design of the behavior program to ensure that all components below are included. All program components will be discussed with the Interdisciplinary Team prior to their implementation.
  - (1) Specification of behavior(s) to be decreased or eliminated, i.e., targeted maladaptive behavior(s). The behavior(s) should be operationally defined to enable staff to clearly identify the behaviors in question.
  - (2) Current operant level of maladaptive behavior(s), e.g., frequency, intensity, and duration.
  - (3) Review of previous programs attempted and specific outcomes, e.g., why they were successful or unsuccessful. If deemed necessary, citation of previously reported or published descriptions of treatment procedures.
  - (4) Functional motivational analysis to identify inferred motivational factor(s) and communicative intent of maladaptive behavior(s). This assessment will include an analysis of the antecedents of the targeted behaviors and a determination whether or not environmental alterations or other manipulations would reduce or eliminate the behavior(s).
  - (5) Method(s) of reducing/eliminating targeted maladaptive behavior(s).
  - (6) Specification of targeted adaptive/replacement behavior(s), i.e., defined operationally to provide objective descriptions of the behavior(s).
  - (7) Current operant level of adaptive behavior(s), e.g., frequency, intensity, and duration.

- (3) Method(s) of training and/or shaping targeted adaptive behavior(s). Whenever appropriate, descriptions of the training schedule, e.g., formal vs. within the context of the clients daily routine, day, time, etc.
- (9) Identification of person(s) responsible for implementation of procedures.
- (10) Specification of when restrictive components are to be implemented.
- (11) Proposed objective(s) for adaptive behaviors.
- (12) Proposed objective(s) for maladaptive behaviors.
- (13) Statements cross-referencing psychotropic medications(s), day programs, and other agency/disciplines where applicable.
- (14) A statement regarding potential physical and psychological risk(s) and/or side effect(s) of the behavioral program.
- (15) Types of data to be collected, i.e., data collection system to allow data-based decisions to be made regarding program effectiveness.
- (16) Frequency of data collection, summary, and review.
- (17) Person(s) responsible for data collection, summary, and review.
- (18) Anticipated duration of program, if clinically indicated or possible. For restrictive behavioral programs, BMC and LHRC approvals are given for 6 months, or indicated otherwise.
- (19) A description of conditions requiring the psychologist's review beyond the normal informal daily/weekly review or formal monthly review should the maladaptive behavior(s) escalate, especially as the program is begun (i.e., an upper limit or "thermostats" to indicate the program is to be reviewed).



- (20) For those clients (a) who have a behavioral consequence which is confining in nature (e.g., posey vest, 4-point restraints, time-out); (b) whose behavior during restraint or time-out could pose a continuing threat to themselves or others; (c) who manifest a psychotic process; the plans shall specify procedures for protecting the safety and well-being of the clients in the event of fire or other emergencies.
  - (21) If a restraint or any other restrictive procedure is to be used as part of the behavior program, a statement by the unit physician indicating that she/he has examined and approve its use, i.e., there are no medical contraindications.
  - (22) A statement by the dietitian that drinks and edible reinforcers have been evaluated based on the individual's nutritional and dietary needs.
- c. Securing all necessary approval, consents, and notifications for the program prior to it's implementation for the stated duration of the program.
  - d. Training staff and documenting such training for proper implementation of all phases or components of the program, i.e., training through positive reinforcement procedures to develop appropriate replacement behaviors or enhance existing adaptive behaviors as well as intervention techniques to address maladaptive behaviors. (See Chapter VII on staff training for additional information.)
- (1) The psychologist and/or psychology assistant (trained by the psychologist) will train the Unit supervisors, i.e., the program manager, team leader, and AM, PM, and NOC developmental technicians, and as many developmental aides as possible in all phases of the program prior to program implementation. Those aides remaining untrained will be trained by their designated supervisor(s). Retraining by the psychology assistant or psychologist per above procedure will occur at least every six months thereafter.

- (2) The training will consist of demonstrated competence in all facets of the behavioral program. This includes: (a) verbal and written understanding of the program procedures, (b) demonstration of all adaptive behavior training, and (c) the application and direct experiencing of reactive interventions techniques.
  - (3) Documentation of this training as indicated by the signature of the individual conducting the training, i.e., psychologist, psychology assistant, team leader, or developmental technicians, will be forwarded to the Chairperson of the Behavior Management Committee (BMC) and the Training Department.
  - (4) The team leader and developmental technicians, following training by the psychologist and/or psychology assistant, will be authorized and responsible for training all remaining staff in all phases and components of the program. In addition, the Unit psychologist and/or psychology assistant is on the Unit daily and are able to model planned intervention procedures as well as respond questions or concerns regarding any aspect of the behavioral program.
  - (5) Only individuals who have been formally train will be considered authorized to implement behavioral programs.
  - (6) Training and documentation thereof will be conducted prior to program implementation and at least every six months thereafter.
  - (7) Persons who have not been trained may not implement any phase or component of the program until such time as they have received training and documentation there of provided as above.
- e. At least monthly monitoring of the program by the psychologist or psychology assistant to include:
- (1) A period of direct observation of behavioral intervention procedures conducted by staff.

- (2) Discussions with residential staff (and involved clinicians) regarding the effectiveness of program procedures.
- f. At least a monthly review of adaptive and maladaptive data by the psychologist, including trend analysis, explanations of the behavioral trend if applicable, possible program changes, etc. in the Interdisciplinary Progress Note section of the Client Record System (CRS). Behavioral data may be furnished to parents, guardians, or authorized representatives who follow existing procedures to obtain information from the CRS.
- g. As a general guideline, a restrictive procedure should be considered for discontinuation if it has not been implemented for 3 consecutive months. Exceptions to this guideline should be justified and approved by the psychologist and IDT and then presented to BMC.
- h. Reviewing the progress of clients with restrictive procedures through BMC and LHRC at specified intervals for those programs which require BMC and LHRC approvals.
- i. Reviewing of the preceding month's data in order to authorize continuation of the procedures for the next month.
- j. All consents, approvals, and notifications resulting in the formal approval of the program will remain in effect as long as the program is active. In the event that a parent/guardian withdraws consent or approval despite the continuing need for the program, as indicated by the psychologist and the IDT, the issue may be presented to the Senior Interdisciplinary Team for consultation and approval. If necessary, an outside consultant acceptable to both parties will be obtained to review the case and attempt to mediate a resolution.
- k. Copies of all restrictive and nonrestrictive programs will be sent to the Chairman of BMC, Client Advocate, and client parent or guardian after all necessary approvals and consents are secured. Approvals and consents may be withdrawn at any time by a client's parent or guardian.

1. Sending a list monthly (or as needed) to the Chief of Psychological Services of the names of clients for whom behavioral programs have been designed and contain restrictive components.

C. **Changes in Behavioral Program and Procedure:** The Psychologist will provide on-going monitoring and assessment of the ecology as well as the clients' total training program (recreation, speech, vocational, etc.) at NVTC. Therefore, adjustments in a client's behavioral program may need to be made on the basis of the client's changing behavioral topography. For example, changes in the positive reinforcement procedure as well as the level of intervention may be necessary, e.g., degree of restrictiveness may be changed from a quiet room consequence to an extinction procedure because of a change in the function served by the maladaptive behavior. All changes must be approved by the Interdisciplinary Team and, if the restrictiveness of the program is increased, additional approvals must also be obtained.

1. **Definitions:**

- a. **Restrictive behavioral program:** Personal and mechanical restraint procedures, time-out, modification of client's rights, psychotropic medication, etc. (see summary table of Programmatic Procedures for more details).
- b. **Program deferral:** A temporary short-term discontinuation of a behavioral program approved by the Interdisciplinary Team.

2. If a client has a restrictive behavioral program (whether because of a restrictive behavioral procedure or the use of psychotropic medication), the program cannot be deferred. If a behavioral procedure for a restrictive program must be changed (e.g., a procedure is no longer effective and/or appropriate and other adaptive and/or maladaptive procedures used), then the procedure(s) must be incorporated (i.e., written) into the behavioral program for the duration of its usage.

3. A nonrestrictive behavioral program can be deferred with the approval of the client's Psychologist and Interdisciplinary Team. However, during the interim, residential staff must be provided with clearly written intervention procedures to address the client's training needs. The psychologist must

also specify the conditions under which the original behavioral program will be reinstated, modified, or discontinued.

4. When a restrictive behavioral program is changed toward greater restrictiveness, all original approvals must again be secured by the psychologist. Additional approvals may be required in some cases when other professional disciplines are now involved, such as the addition of edible reinforcements as a part of the training program (e.g., the dietitian's approval should now be added to the list of approvals). (see summary table of Programmatic Procedures).
5. When a behavioral program is changed from being nonrestrictive to restrictive, the standard procedure for securing approvals for a restrictive program must be followed.
6. When a restrictive behavioral program is changed toward lesser restrictiveness or is now nonrestrictive, the change must be approved by the Interdisciplinary Team and a memo describing the change forwarded to the chairperson of BMC.

D. Programmatic Procedures (see summary table for approvals, concerns and notifications necessary).

1. Calm: A clinically determined period of time of sustained non-agitated behavior not to exceed ten (10) minutes. Its function is to ensure that the client is, indeed, clinically calm before returning to the activities available to him/her and thereby reduce the probability of a return to the previous state of disruptive behavior. Duration of calm, e.g., calm for 2 minutes, is to be established based on prior experiences with observations of the client.
2. Overcorrection: Any type of repetitive actions implemented as a consequence of behavior. Overcorrection procedures shall not be prescribed for a period in excess of 30 minutes. The total amount of time per day a client spends in overcorrection procedures shall not exceed two (2) hours within a twenty-four (24) hour period for repeated incidents without prior approval of the Director of NVTC.

- a. **Graduated Restitution:** Returning the environment to its normal state with the minimum physical intrusion necessary. For example, picking up clothing, placing them on hangers, and returning them to the closet after they have been thrown out by the individual.
  - b. **Graduated Positive Practice:** Repeating the appropriate form of the behavior with the minimum physical intrusion necessary. For example, as a consequence of deliberately spilling or throwing food during a meal as an intentional act of misbehavior, a client will not only perform restitution but also wipe the table and clean the immediate area after a meal.
  - c. **Graduated Contingent Exercise:** Repeating a topographically dissimilar response with respect to the targeted maladaptive behavior(s) with the minimum physical intrusion necessary. For example, as a consequence of inappropriate sexual touching of another client or staff, a client will touch his toes ten times for a specified period of time.
  - d. **Graduated Negative Practice:** Repeating the targeted maladaptive behavior with the minimum physical intrusion necessary. For example, as a consequence for constantly moving furniture resulting in the disturbance of other clients, a client will be guided through the act of moving furniture for a specified period of time.
1. **Contingent Exclusion:** Temporary removal of a client from ongoing activities as a consequence of a maladaptive behavior. As with all programs, but especially with contingent exclusion procedures, it is necessary to specify those conditions under which a psychologist's review will be done. This is to ensure that the client is not excluded unduly from significant portions of training for unnecessarily prolonged period of time. With the exception of "On Unit During Program Time," "Unit Restriction," and "Contingent Access to Activity," no order may exceed one hour. See Section IV.B.9., Extension of Programmatic Procedures.

As a general policy, exclusion procedures are not used in response to self-injurious behaviors (SIB). There are exceptions, however, when exclusion may be

an appropriate response to SIB as determined by the functional analysis and the clinical judgment of the psychologist and IDT and approved by BMC and LARC. For example, exclusion may be an appropriate procedure if the SIB is motivated by attention and does not escalate to an intensity where personal restraints are required to prevent possible tissue damage.

If exclusionary procedures are used as reactive interactions to physical aggression to people and the client begins to display SIB, the psychologist, in conjunction with the physician, must clearly described the contingency procedures in the behavior program to address this situation. That is, the program must indicate the conditions under which staff will intervene, e.g., when to ignore the behavior and when they will physically stop the SIB.

- a. In Room: The client is escorted to his/her own bedroom or to a vacant room with the minimum physical intrusion necessary. Physical procedures should not be used to maintain the client in the designated room.
- b. In-Seat: The client is escorted to and seated (but not held in) with the minimum physical intrusion necessary. Nonphysical procedures can be used to keep the client seated.
- c. Off-Unit: The client is escorted off the unit (e.g., to a hallway or outside the building) with the minimum physical intrusion necessary (NOTE: If this procedure is utilized the written narrative to the behavior program should include documentation that the client is capable of utilizing this procedure in a positive manner, i.e., not running away or resorting to displacing anger/aggression to passersby or property.)
- d. In Corner: The client is escorted to a corner of the room with the minimum physical intrusion necessary. The client is maintained in the designated area through verbal/gestural prompts, physical presence, and other nonphysical procedures.
- e. Quiet Room/Area: The client is escorted to a neutral unlocked room/area other than his/her bedroom with the minimum intrusion necessary. The room/area should be ventilated, well lit,

free of safety hazards, and unless otherwise contraindicated, equipped with a mat. Egress from the room/area is not prevented by the staff monitoring the procedure.

- f. Time out from reinforcement with staff in the room with the client: The client is escorted with minimum physical intrusion to a room with a staff member in the same room. The room should be ventilated, well lit, free of safety hazards, and, unless otherwise contraindicated, equipped with a mat.
- g. Time out from reinforcement with staff outside the room: The client is escorted to a time out room with the least amount of physical intrusion necessary. The client is prevented from leaving the time out room with a hand-held locking bar (i.e., the door becomes unlocked when the bar is released) rather than a keyed lock. The room is ventilated, well lit, free of safety hazards, and, unless otherwise contraindicated, equipped with a mat.

- (1) The individual will be released after a prescribed period of calm, not more than ~~5~~ 10 minutes in the room. However, if it is clinically indicated that a longer duration is necessary to achieve calm and/or significantly increase the probability that further aggressive episodes can be reduced, then the interdisciplinary team, with the approval of BMC, LHRC, and other approving bodies, may extend the duration for specifically identified clients to not more than 60 minutes in the room. This change is then reflected in the client's formal program.
- (2) Staff must remain immediately outside the door at all times for purposes of unobtrusively monitoring the client.
- (3) Criterion for use and discontinuance of time-out procedure, i.e., plans to move to less restrictive means of modifying the targeted behavior, must be clearly specified in the client's program.

- h. On unit during program time: The client is to remain on the unit for only the duration of



program time in which he/she was intentionally disruptive or refused to attend, e.g., remain on the unit rather than go to recreational activity such as a dance or swimming.

- i. Unit restriction: As a consequence of specific maladaptive behaviors, e.g., consistently runs away to avoid doing his/her assigned chores, the client is required to remain on the unit for a period of time greater than the duration of program time where he/she was disruptive but not to exceed twelve (12) hours.
- j. Contingent access to activity: A client's access to preferred activity not related to training needs or goals is contingent upon demonstration of targeted adaptive behavior(s) or withholding targeted maladaptive behavior for a specified period of time, e.g., not becoming upset for an entire week when asked by staff to bathe will entitle the client to go on a field trip to the circus.

4. Meal Modifications: Altering any condition of a client's normal meals, including the amount consumed, where the meal is consumed, and when the meal is consumed when the modifications are part of a planned behavioral program. Behavioral programs do not employ techniques that may result in denial of nutritionally adequate diet.

a. Limitations:

- (1) Access to meals may not be used contingently as part of the behavioral program. The client must be allowed reasonable access to his/her meal on a non-contingent basis at the prescribed time.
- (2) If a client, through his/her own behavior, refuses the meal, staff must attempt to ascertain the reason(s) for the meal refusal. If the client simply did not want that particular meal, then, short of danger to health and depending on the developmental or functioning level of the client, staff is under no obligation to make special arrangement to feed him/her.

- (3) If a client should refuse or miss two (2) consecutive meals, the unit physician must be notified by the unit staff and be responsible for monitoring the client's nutritional intake and overall health. Each meal missed or refused must be documented by the unit staff.
- (4) If a client is involved in a behavioral procedure prior to and extending through mealtime, unit staff must arrange for the meal to be provided to the client after the procedure is terminated and the client is returned to a state of calm. If the meal was originally served off the Unit, the meal may subsequently be offered again at the off-Unit site or brought back to the Unit with the client, whichever is more appropriate.

b. Procedures:

- (1) Contingent access to extra portions: The client gains access to extra portions of identified favorite foods by demonstrating targeted adaptive behavior(s) at mealtime. "Extras" are defined as approved portion (by the dietitian and physician) above those already indicated by the physician's dietary prescription for that client.
- (2) Removal from the group at mealtime: The client remains in the designated dining area to complete his/her meal; contingent upon the presence of targeted maladaptive behavior(s), the client is removed from the group to a separate table. (NOTE: This procedure is a consequence of targeted maladaptive behavior(s) and is not to be equated with seating a client at a separate table as prerequisite for intensive eating skills training.)
- (3) Alternate location of Meal: A programmatic extension of limitation described above in which meal(s) is/are served to a client in a designated location other than the designated dining area.

5. Modifications of Residents' Rights: See Instruction 5810, "Resident Bill of Rights" and Rules and Regulations to Assure the Rights of Residents of Facilities operated by the Department of Mental Health and Mental Retardation (DMH 26 7/83).

Rights which may be restricted include but are not limited to:

- a. "freedom to have or refuse private visitation with anyone the client chooses";
- b. "freedom to keep and use personal clothing and other personal items";
- c. "freedom to possess and spend personal funds";
- d. "freedom to view, hear or receive television, radio, books and newspapers whether privately owned or in a convenient library or day room";
- e. "freedom to make purchases in canteens, vending machines, or stores selling a basic selection of food and clothing"; and
- f. "freedom to use leisure material, recreational facilities, and enjoy the outdoors".

Rights which may not be restricted, denied or otherwise abridged include:

- g. "The right to be called by his preferred legal name".
- h. "The right to be protected from harm, abuse and exploitation".
- i. "The right to a nutritionally adequate, varied and appetizing diet prepared and served under sanitary conditions and served at an appropriate temperature".
- j. "The right to a safe, sanitary, and humane physical environment, including but not limited to:
  - (1) 'access to the outside and leave the residential Unit';
  - (2) 'residential accommodations affording reasonable privacy and private storage space';

- (3) 'operating toilet, lavatories, showers, and tubs that are adequate in number and design and that afford privacy';
- (4) 'direct outside air ventilation provided by an operable window or air conditioner';
- (5) 'windows or skylights in all major areas used by patients or client';
- (6) 'clean air, free of noxious odors';
- (7) 'room temperatures that are comfortable in all seasons'."

k. "The right to comfortable, clean, and seasonally suitable clothing appropriate to the age and size of the client, for the exclusive use of the client, and in sufficient quantity to allow for a daily change of clothing, provided however that:

- (1) 'the facility need only provide a client with such clothing if the client is unable otherwise to obtain it, in which case the cost of the clothing may be added to the cost of treatment subject to reimbursement', and
- (2) 'the use of such clothing may be restricted if specifically ordered by the same person and for the same period or shorter, who orders time out pursuant to Section VII, if the client is provided with alternative clothing adequate for warmth and modesty'."

l. Each client shall be treated in that setting and under those conditions that are least restrictive of his physical and personal freedom while being consistent with his/her individual habilitation needs and the safety and rights of others.

m. "The right to apply for and to receive assistance in applying for and making full use of any public services or benefit to which the client may be entitled, including but not limited to educational or vocational services, housing assistance, welfare benefits, benefits

or services under Titles II., XVI., and XIX., or the Social Security Act, and services from a legal aide society."

- n. "The right to communicate in confidence with any person by mail or telephone, and to be assisted in exercising this right subject to the following conditions and limitations.
- (1) 'Whenever a staff member has probable cause to believe that mail received by a client contains contraband or anything that would create a danger to the client or others, the mail may be opened (but not read), by the staff member in the presence of the client and the advocate';
  - (2) 'upon request, an indigent client is entitled to sufficient letter writing material and postage to mail one letter per day, or the equivalent';
  - (3) 'upon request, and subject to appropriate management limitations, an indigent client is entitled to make, without charge, local telephone calls from a telephone within the facility, provided such calls do not result in additional cost to the facility'; and
  - (4) 'nothing herein shall obligate the facility to assist in perpetration of or to refrain from reporting or otherwise intervening to prevent any criminal act'."
- o. "The right to communicate or consult, in private, with any lawyer, judge, legislator, regularly ordained clergyman, licensed health care practitioner, the client's authorized representative or the advocate who visits the client, provided however, that whenever a physician or doctoral level psychologist believes that such access will create a danger to the visitor, the communication may be prohibited or restricted unless the visitor has been informed of the danger involved and has agreed to hold the state harmless for any injury sustained by the visitor during the visitation."

p. "The right to attend or refuse to attend any religious services held on the premises of the hospital or other facility, and to engage in any recognized religious practices, including refusal of treatment or other services, provided that such services or practices neither present a danger of bodily injury to the client or others, or interfere with the rights of other patients or clients under this paragraph".

6. Rules and Regulations to Assure the Rights of Residents of Facilities Operated by the Department of Mental Health and Mental Retardation, DMH 25 7/83. As such, restriction of client's right falls into two categories, each having its own set of approvals and review sequences.

a. Unit based Rules of Conduct: "...the freedom of clients may be restricted in the enforcement of rules of conduct designed to maintain an orderly, safe and therapeutic environment when such rules are generally applicable to groups of clients and have been approved by the LHRC." (Rules and Regulations to Assure the Rights of Residents VII.B.1. p. 18). Managerial, unit-based rules of conduct must be written and approved by the Interdisciplinary team serving that particular unit. Subsequently, the rules of conduct must be presented to and approved by LHRC. Limitations, justifications and review sequences for unit-based rules of conduct are delineated in the Rules and Regulations to Assure the Rights of Residents (VII.B. p.18). As such, unit-based rules of conduct are managerial issues, and not individualized behavior therapy procedures. They are only described here to provide a basis for distinguishing the two.

b. Individual Behavior Therapy Programs: These rights may be modified as part of a planned behavior therapy program and not according to "on the spot" or arbitrary decisions by staff. In the program, evaluation by the clients' Interdisciplinary Team must be made to respond to the rights modification being proposed. The plans must include a clear rationale for the proposed rights modification as well as specify the conditions under which the modification would be removed.

7. **Protective/Preventative clothing:** Articles of non-removable clothing (including gloves and shoes) which limits a client's ability to engage in maladaptive behaviors but do not restrict his/her freedom of movement. When used contingently as part of a behavioral program (as opposed to a medical order), protective/preventative clothing should not be applied for more than 2 consecutive hours unless there is a clear justification for a longer duration documented in the behavioral program. This procedure is not considered to be restrictive per NVTC policy.

8. **Restraint:** A procedure which Limits the freedom of movement of a client. Unless clinically indicated, less restrictive methods must first be attempted immediately prior to the application of a physical restraint. Only the minimum amount of restraint necessary to manage the individual's behavior is used during the implementation of a restraint program.

Restraints employed on a response contingent basis are used only until the individual is calm (for example, calm may be defined as "2 minutes calm," i.e., the individual has demonstrated that he/she is not clinically calm unless 2 consecutive minutes of nonagitated behavior have occurred).

The extent and frequency of monitoring of restraints will vary according to the type and design of the device and the condition of the individual. For example, 4-point restraints will require constant visual monitoring while soft mittens or a helmet may require less.

With the exception of mechanical restraints used as response prevention devices, no order may exceed one hour. See Section V.D.10. Extension of Programmatic Procedures.

a. **Instructed relaxation:** The client is verbally or gesturally prompted or physically guided into but not physically held in a specified relaxation position. Shadowing is permitted but at no time is the client to be physically maintained in the position. Therefore, this is not a form of restraint.

b. **Personal Restraint:** The client is physically guided into and maintained in a specified

position based on the system of physical interaction as prescribed by the Mandat System. If there are any significant deviations from the recommended restraint procedures, as determined by the Interdisciplinary Team, then these differences must be clearly described in the client's behavioral program. The specific restraint position will be individually determined based on restrictions or limitations imposed for medical, physical, and behavioral reasons.

- c. **Blocking:** A lower level form of personal restraint in which movement of the client's limb(s) are severely limited by staff, e.g., hands are held at his/her sides by staff to prevent the display of a targeted behavior.
- d. **Mechanical Restraint:** Not to be equated with protective or supportive devices defined in NVTC Instruction §301, a mechanical restraint involves the use of a devices to restrict or prevent expected movement of a client. The visual/auditory monitoring of the client while in restraint varies with the type of restraint and conditions under which the restraint is applied. For example, a client in a 4-point supine restraint is under continuous visual monitoring while a client in a helmet for biting is under auditory but not necessarily visual monitoring.
  - (1) Mechanical restraint devices are inspected prior to each use to ensure that they remain in good repair and are free of protrusions that may cause injury.
  - (2) Only devices identical to those specified in the written behavior management program are used to restrain the individual. Please refer to Appendix L for the list of all mechanical restraint devices approved by NVTC.
  - (3) Safety and well-being of the individual is checked at least every 30 minutes during each application. If more frequent checks of the mechanical restraints are indicated, such as for a highly active and resistive client, more frequent checks must be clearly specified in the behavioral program. If staff has any



reason to believe that the client is in pain due to physical/medical conditions, they should immediately contact the nurse or physician. Medical treatment, if warranted, will take precedence over the use of behavioral consequences.

- (4) Although the duration in mechanical restraints varies from case to case, depending upon such conditions as nature, severity, and function of the maladaptive behavior, environmental/residential limitations, behavioral history, and documented learning history and potential of the client, all individuals in mechanical restraints must be released for a minimum of 10 minutes every 2 hours and, unless asleep, provided with an opportunity for motion, exercise, liquid intake, and toileting.

(5) Procedures:

- (a) As a response consequence, the mechanical restraint functions as an analogue to timeout from reinforcement procedures. The duration in restraints will be "until calm" to a maximum of 1 hour. For example, a helmet may be contingently applied "until calm" for headbanging but not to exceed 1 hour.
- (b) As a response prevention procedure, a mechanical restraint is differentiated from a medical protective device on the basis of the degree of control the client has over the behavior(s) for which they are being used. A helmet worn to protect a client from possible injury due to seizures is a medical protective device; similarly, a helmet to prevent pica (after possible medical causes such as nutritional deficits have been eliminated) is a behavioral/medical mechanical restraint. The former helmet usage is not subject to this policy whereas the latter is.

In addition, when used as a response prevention procedure, the duration in restraints may vary from "until calm" to a maximum of 2 hours, e.g., a helmet for pica may be applied as a consequence "until calm" or applied noncontingently for 2 hours where pica is perceived by the physician to be a health and safety issue.

- (c) Screening: A special case of use of a mechanical restraint in which a device is placed on the client but does not interfere with normal scheduled activities or training. For example, a surgical mask is placed over the client's mouth for a limited period of time as consequence for spitting.

- 9. Aversive Stimulation: According to the 1987 standards of ACDD (Accreditation Council on Services for People with Developmental Disabilities), "Aversive conditioning refers to the application, contingent upon the exhibition of maladaptive behavior, of startling, unpleasant or painful stimuli, or stimuli that have a potentially noxious effect" (page 65). ACDD also states that: (1) aversive conditioning "must also be limited to situations in which the interdisciplinary team, the behavior management committee, and the human rights committee concur that to withhold the procedure would cause irreparable harm to the individual" (page 67), and (2) the procedure is used only when the client's behavior "precludes his or her development, and less negative procedures have, in the immediate past, been documented to be ineffective in reducing or eliminating this particular behavior" (page 72).

NVTC does not subscribe to the use of aversive conditioning as a treatment procedure.

- 10. Extension of Programmatic Procedures: Although most orders for programmatic procedures do not exceed one hour, it may be necessary, from time to time, especially during the initial phase of program implementation, to extend the duration of the procedure based on the client's behavior, i.e., not calm. If, toward the end of the hour, the client continues to exhibit signs of not being calm, staff

should contact the following for authorization to extend the procedure: (1) the unit psychologist; (2) on-call psychologist; (3) Chief of Psychological Services; (4) physician; (5) NVTC Director, or; (6) Acting NVTC Director.

The extension will be for only one additional hour "until calm." The extended procedure must be terminated once the client returns to a calm state or at the end of the additional hour regardless of the client's behavior, whichever occurs first. In extreme emergencies where it is unequivocally clear that the client will be a significant threat to him/herself or others, the Psychologist should be contacted for consultation.

Following the extension of programmatic procedures, a Crisis Management Documentation Form must be completed and forwarded to the Program Manager within twenty-four hours or the first working day following the incident. The Crisis Management Documentation Form will then be routed first to the Program Manager and the Unit Psychologist and then to selected members of the Interdisciplinary Team, chairman of BMC, Risk Manager, NVTC Director, and the Resident Advocate for their review and comments.

#### E. Non-programmatic Uses of Restrictive Procedures

1. Collection of Baseline Data: During this period, it may be necessary to try a variety of behavioral procedures not only for the purpose of managing the client and deal with situations as they arise but also to collect data to document each behavioral episode. Baseline data is essential in the event of future program development and evaluation.

Procedure which may be used during this time are:

- a. Restitution
- b. Quiet room/area, bedroom, in-seat until calm
- c. Physical guidance
- d. Personal restraint until calm (requires completion of the Crisis Management Form).

2. Day to day procedures: Data and documentation are not required in these situations as they are standing procedures which are available to staff to

help bring a given (low frequency) behavioral situation under control. These procedures include:

- a. Restitution
  - b. Quiet room/area or bedroom until calm
  - c. Removal from the group until calm
3. Crisis Prevention and Management Procedures: On an emergency basis, certain restrictive procedures may be implemented in order to manage a client's behavior that clearly poses a threat to self or others.

It is critical to distinguish between procedures used in crisis management and those used as part of a planned behavior treatment programs. A behavioral crisis is an exceptional event which occurs so infrequently that a systematic plan of intervention has not been formally developed. Restrictive procedures in this context may not be used as an aversive consequence but rather strictly as a method of calming the client and managing his/her behavior.

When a client becomes highly aggressive, there is typically a reason (with the possible exception of dually diagnosed individuals). In most cases, there are early signs that he/she is stimulated and is building up to an aggressive outburst. Therefore, an attempt at early intervention designed to prevent the outburst or deal with it before it becomes violent is necessary and expected before restrictive procedures are applied.

Crisis management may be conceptualized as a sequence of procedures that progressively become more restrictive for the client. Interactions with the client should begin with nonphysical procedures whenever possible (i.e., the graduated approach as described by the Mandt system). The point at which staff enter into this sequence will depend on the behavior(s) being exhibited by the client.

a. Preventive/Supportive Intervention

- (1) A client's behavior may typically include an unusual departure from his/her normal routine, e.g., agitated behavior such as complaining, screaming, pacing or possibly withdrawing from others.

(2) Appropriate staff response at this stage includes a variety of supportive techniques such as:

- (a) Attempting to determine whether or not the client is in physical discomfort, e.g., ill or injured, and requires medical treatment;
- (b) Talking to the client to find out what is wrong, helping to problem-solve, or simply calm the client with a soothing tone of voice;
- (c) Providing the client with sufficient personal space and reducing excessive environmental stimulation, such as noise and activity immediately around the client;
- (d) Redirecting the client into a specified activity that he/she can easily perform and that will maintain his/her interests;
- (e) Presenting requests in a positive, supportive manner and giving the client more flexibility where possible in meeting these requests;
- (f) Keeping other clients away who may tease, bother, or somehow stimulate the agitated client or away until the client is calm.

b. Limit setting intervention

- (1) Client's behaviors may typically include a wide range of behaviors, such as continued agitation, tantrums, verbal aggression, threats of aggression, or isolated acts of aggression to self, others or property.
- (2) Appropriate staff responses at this stage include:
  - (a) Identifying the most effective strategy to manage the individual, including using the right person(s), approaching the client in a nonthreatening manner, using a calm

controlled voice, respecting the client's personal space, etc.;

- (b) Identifying and labeling the client's behavior and/or emotional state for him/her and suggesting an immediate course of action, e.g., "(Name), you're upset so let's sit down and talk about what's troubling you."
- (c) Identifying appropriate limit-setting procedure(s) for the client given the client's background, previous training and experience, and the present situation. As a rule of thumb, the client should be offered 2-3 options in order to permit him/her some control as to what will be done. For example, the client may be given the instruction "hands down," or "Let's go to your room," or "Let's go to the quiet room."

If the client is exhibiting responses related to aggression to self, a limit-setting procedure designed to stop the behavior might be "Hands down". On the other hand, if the client is exhibiting a response related to aggression to others, a suggested limit-setting procedure might be, "Let's go to your room." However, if the client is exhibiting responses related to aggression to property, a limit-setting procedure might be, "Let's go to the quiet room." The duration of any limit-setting procedure would be until the client is calm.

If the client refuses to comply with the limit setting prompt, backup assistance should be obtained and the client once again given the prompt. The staff who began the procedure should generally continue the exchange unless there is clear indication that another staff would be more effective. If the client again refuses to comply with the limit setting prompt, he/she should be physically guided into the prompt

(e.g., hands blocked at the side, escorted to room, or escorted to quiet area). Follow through at this stage is important; a client should not be given a specific prompt unless the prompt can be carried out.

### **C. Crisis Intervention Procedures**

(1) The client's behavior is out of control in a manner that is harmful to self or others. The behavior at this stage is typically characterized by repeated acts of aggression or self abuse and the client's inability to respond to supportive or limit setting procedures.

#### **(2) Staff Responses:**

(a) **Crisis Management:** As always, the graduated procedure as prescribed by the Mandt system of staff-client interaction should be used. For example, consideration should be given to such factors as the need to separate the client from the group, whether or not the types and number of staff are optimal to manage the client, what form of staff-client interaction is needed, etc. Only when deemed necessary for the protection of the client, others, or significant property, should physical interaction procedures based on the Mandt system be used to manage the client safely.

All physical interactions must use the least amount of external management to bring the crisis under control. If there is any significant departure from the prescribed physical interaction procedures, this must be described in the Crisis Management Documentation Form (see Appendix E).

It is especially important to note here that the Mandt System of physical restraints should be used in which the intent of the procedure is to manage the aggressive behavior

using the least amount of external management necessary to deal with the client's behavior. If necessary, this may involve holding the arms, body, and legs in such a way as to ensure a safe and effective restraint.

The client should be regularly assured that he/she will be released as soon as he/she calms down and is quiet for a couple of minutes. However, staff should not attempt to yell or shout instructions over the client's loud or inappropriate verbalizations but wait until the client is able to understand what is being conveyed by staff. When the client is quiet for a full two minutes, he/she should be released and then slowly reintegrated into the on-going activity.

If, (a) staff believes that physical restraints is inappropriate or ineffective, i.e., imminent threat of injury to staff or client or (b) the client remains highly agitated after approximately 30 minutes of Crisis Management and is showing no signs of calming, the unit psychologist should be contacted. If unavailable, then call the on-call psychologist; Chief of Psychological Services; physician; NVTC Director; or NVTC Acting Director for consultation regarding other possible interaction strategies. Alternative actions which may be taken includes: mechanical restraints, program extension, psychotropic medication, or other emergency procedures).

NOTE: "In order to expedite reaching on-call psychologists during evenings, nights, weekends, or holidays, the units are requested to notify the Roving Team Leader (RTL) or Duty Officer of need. The RTL/Duty Officer will evaluate the condition and call/page the



appropriate psychologist." (Memo dated 11/4/92 from Leon Rose.)

Crisis management during vehicular transportation: If crisis management procedures are required vehicular transportation, e.g., a client becomes highly disruptive or aggressive and (a) cannot be managed by nonphysical and physical Mandt procedures and (b) the client's behavior is judged by staff to jeopardize the well-being and safety of other passengers and motorists, then mechanical restraints may be used as part of the crisis management procedure.

- (b) Program Extension: Extension of Crisis Management procedures beyond the hour cannot be for more than one additional hour. This must be authorized by the unit psychologist; or if unavailable, the on-call psychologist; Chief of Psychological Services; physician; NVTC Director; or NVTC Acting Director prior to the actual extension.
- (c) Psychotropic Medication: If the client's behavior is out of control and (a) his/her behavioral program, and/or (b) Crisis Management have been tried repeatedly, including the use of program extensions, and/or has been implemented for a long duration, staff should contact the unit psychologist for consultation. If the psychologist is unavailable, contact the on-call psychologist, Chief of Psychological Services, physician; NVTC Director, or NVTC Acting Director.

When the ongoing behavioral procedure is interrupted to administer an emergency psychotropic medication, the behavioral procedure may be interpreted to have been discontinued depending upon the nature of the procedure. For example, if the

client was in Time Out and the client did not attempt to aggress or leave the area without approval immediately after the medication was given, then the procedure has been terminated and any subsequent use of Time Out can be viewed as another behavioral episode. On the other hand, if the client was in restraint at the time emergency medication was administered, then the behavioral procedure has not been significantly changed and should be interpreted as a continuing behavioral episode.

If emergency psychotropic medication or other emergency measure is indicated, the individual who was contacted will follow NVTC Instruction 5302, "Psychotropic Medication", Emergency Procedures Section.

- (d) Mechanical Restraints: However, if, in the opinion of the physician contacted that emergency psychotropic medication is not indicated, the physician may authorize the emergency use of mechanical restraint (see NVTC Instruction 5301, "Use of Protective Devices."

Mechanical restraints may also be ordered by a psychologist if it is indicated by the behavioral crisis. For example, if the psychologist contacted believes that significant health and safety issues is or may be present with the continued use of personal restraints, then mechanical restraints may be authorized. (See "Rules and Regulations to Assure the Rights of Residents of Facilities," DMHRSAS, 7/83).

(3) Psychologist's responses:

When a psychologist must be reached for consultation because a client is in crisis, the Unit psychologist should be called first. If he/she is unavailable, a backup psychologists should be contacted

using the posted "backup" schedule. The psychologist will then solicit information from staff to determine the most appropriate course of action. The psychologist will ask:

- (a) Actual or hypothesized antecedents or precursors to the crisis and what steps have been taken to address the probable causes. Particular attention should be given to whether considerations have been given to environmental and medical issues.
- (b) Why a specific crisis intervention procedure is being requested, i.e., program extension or emergency psychotropic medication.
- (c) When the behavioral crisis began, including frequency, duration, and intensity of the behavioral episode(s).
- (d) The client's mood, behavior, and general well-being prior to the behavioral crisis.
- (e) If applicable, if specific behavioral interventions have been tried in the past, what procedures have been successful, etc.
- (f) If emergency psychotropic medication is indicated, then, if known, what and when the last prescription was administered and the client's reaction to the medication.

The psychologist will then provide the staff with a recommended course of action and the rationale for that decision.

- (4) Documentation of Crisis Management: When crisis management, extension of crisis management, the reactive component of a formal behavioral program, emergency psychotropic medication, or other emergency procedures must be implemented, a Crisis Management Documentation Form must be completed immediately after the

behavioral episode. The report is then routed according to the sequence specified in the Form, i.e., forwarded first to the Program Manager, then to the Unit Psychologist, Nursing/Medical, QMRP, Risk Manager, Client Advocate, NVTC Director, and then to Psychological Services for purposes of documentation and monitoring.

The Crisis Management Documentation Form requests the following information:

- Name and registration number
- Time of crisis management
- Location of crisis management
- Type of crisis management and person authorizing the procedure(s)
- Behavior(s) displayed which resulted in the use of crisis management
- Antecedents to maladaptive behavior(s)
- Intervention procedures used prior to and during crisis management
- Client's response to crisis management (intensity in 5 minute increments)
- Medication and dosage, if applicable (including client's response to medication)
- Injuries and other outcome of crisis management procedures
- Person completing form
- Other staff persons involved in the crisis management
- Routing order for comments and/or recommendations

Whenever emergency intervention procedures are repeated more than three times within twelve months, the psychologist must review the reports and enter an ID note in the client's CRS regarding suspected or actual motive(s) for the behaviors and proposed course of action to be taken. The response by the psychologist can take various forms, including statements that (1) modifications be needed in the existing behavior management program, e.g., changing a training procedure or adding a restraint component, or (2) no program changes are being considered, e.g., the conclusion of the psychologist

and the IDT that emergency intervention procedures were used because of a medical condition (for example, the client was in pain because of a reoccurring illness) and the client had no other ways to express his/her extreme discomfort.

- (5) Interim Procedures: In cases where true behavioral emergency situations arise (e.g., a sudden display of highly intense aggression to self or others) in which immediate intervention procedures are necessary, emergency interim procedures may be implemented for a period of time not to exceed the next scheduled meeting of BMC or LHRC, whichever occurs at the latest date. (See page 20 for details.)

## VI. SUMMARY OF PROGRAMMATIC USES OF RESTRICTIVE PROCEDURES

The following table summarizes programmatic uses of intrusive and restrictive procedures. As an aid, generic examples are also provided. Level of consent for the various procedures are indicated. To interpret the levels of consent columns:

- "X" Indicates prior written consent/approval necessary
- "O" Indicates prior notification necessary.
- "C" Indicates copy of the program is to be forwarded to this person as the program is being implemented.
- "P" Indicates notification is necessary but may be after the fact.

In those cases where no substitute consent can be obtained for a client for whom restrictive procedures are clinically indicated, the psychologist will notify the Director, NVTC, and Resident Advocate.

The psychologist will also notify the Director, NVTC, and the Resident Advocate in those cases where substitute consent is not required but only notification is indicated and there is not parent/guardian/relative involved for the client.

See NVTC Instruction 5713 for additional information.

## APPROVALS/NOTIFICATION

All programs must be approved by the IDT and Psychologist. However, programs categorized as restrictive by NVTC requires additional approvals. The following procedures are illustrative of the different types of reactive procedures and the levels of approvals required before a they can be implemented.

MD = Physician  
P/G = Parent/Guardian  
BMC = Behavior Management Committee  
HRC = Local Human Rights Committee  
DIR = Director of NVTC  
ADV = Human Rights Advocate (notification required only)

| Procedure                     | Generic Description of Use                                                                                                                                     | MD | P/G | BMC | HRC | DIR | ADV |
|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|-----|-----|-----|-----|
| Graduated positive practice   | As a consequence of toileting error, client is guided through cleanup procedure with minimal intrusion necessary for a time period not to exceed 10 mins.      | O  | P   | C   | -   | -   | C   |
|                               | For fixed time periods greater than 10 minutes but not to exceed 30 mins.                                                                                      | X  | X   | X   | X   | -   | O   |
| Graduated contingent exercise | As a consequence for teasing, a client is guided through a non-strenuous activity with minimal intrusion necessary for a period of time not to exceed 10 mins. | O  | P   | C   | -   | -   | C   |

| Procedure                           | Generic Description of Use                                                                                                                                                     | MD | P/G | BMC | HRC | DIR | ADV |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|-----|-----|-----|-----|
|                                     | For fixed time periods greater than 10 mins. but less than 30 mins., for strenuous activity of any duration not to exceed 30 mins.                                             | X  | X   | X   | X   | -   | O   |
| Graduated negative practice         | As a consequence for throwing objects, client is guided through the act of throwing these objects with minimal intrusion necessary for any time period, not to exceed 30 mins. | X  | X   | X   | X   | -   | O   |
| Graduated restitution               | As a consequence for overturning furniture, the client is guided through the act of restoring the environment to its normal state with minimal intrusion                       | O  | P   | C   | -   | -   | C   |
| Contingent access to extra portions | As a consequence for stealing food, client loses access to designated extra portions of approved favorite food                                                                 | O  | P   | C   | -   | -   | C   |
| Removal from group at mealtime      | As a consequence for stealing food, client is seated at another table away from the group to eat his or her meal                                                               | O  | P   | C   | -   | -   | C   |



| Procedure                                                  | Generic Description                                                                                                                       | MD | P/G | BMC | ERC | DIR | ADV |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----|-----|-----|-----|-----|-----|
| In room, quiet area, corner, seat, or off unit             | As a consequence for disruption, client is escorted to room, etc., until calm. Not to exceed 60 mins.                                     | -  | P   | C   | -   | -   | C   |
| On unit during program                                     | As a consequence for disruption during a day program, client spends the following workday on the unit for the duration of the day program | -  | P   | C   | -   | -   | C   |
| Unit restriction                                           | As a consequence for disruption during a day program, client is required to remain on the unit for a period not to exceed 12 hours.       | X  | X   | X   | X   | X   | O   |
| Time out from reinforcement with staff in room with client | As a consequence for disruption, client is placed in a room with a staff member in the same room. Not to exceed 60 mins.                  | X  | X   | X   | X   | -   | O   |
| Time out from reinforcement with staff outside the room    | As a consequence for aggression, client is placed in a room with the door held by staff to prevent egress. Not to exceed 60 mins.         | X  | X   | X   | X   | X   | O   |

| Procedure             | Generic Description                                                                                                                                   | MD | P/G | BMC | ERC | DIR | ADV |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|-----|-----|-----|-----|
| Instructed relaxation | As a consequence for tantrums, client is verbally prompted or guided to maintain a specified position (relaxation) until calm. Not to exceed 60 mins. | O  | P   | C   | -   | -   | C   |
| Protective clothing   | As a consequence for stripping and/or tearing clothes, clothing which cannot be removed or torn by the client will be applied for 2 hours             | X  | X   | X   | X   | X   | O   |
| Personal restraint    | As a consequence for aggression, client is physically guided and maintained in a specified position until calm. Not to exceed 60 mins.                | X  | X   | X   | X   | X   | O   |
| Blocking              | As a consequence for hitting, client's hands are held at his/her side until calm. Not to exceed 60 mins.                                              | O  | P   | C   | -   | -   | C   |
| Physical screening    | As a consequence for spitting, a surgical mask is placed over the client's mouth until calm. Not to exceed 60 mins.                                   | X  | X   | X   | X   | -   | O   |

| Procedure                       | Generic Description                                                                                                      | MD | P/G | BMC | HRC | DIR | ADV |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------|----|-----|-----|-----|-----|-----|
| Visual or Facial Screening      | As a consequence for aggression to others, a hand is placed over the client's eyes until calm. Not to exceed 60 minutes. | X  | X   | X   | X   | X   | O   |
| Mechanical restraint            | As a consequence for self-injury, client is placed in arm restraints until calm. Not to exceed 60 mins.                  | X  | X   | X   | X   | X   | O   |
| Contingent access to activity   | As a consequence for aggression, client loses access to specific preferred activity (not related to training needs)      | -  | P   | C   | -   | -   | C   |
| Alternate location of meal      | As a consequence of disruption in the dining area, client's next meal is served in the activity room                     | X  | X   | X   | X   | -   | O   |
| Modification of client's rights | In order to teach appropriate budgeting skills, client denied access to money is limited                                 | X  | X   | X   | X   | -   | O   |

## VII. STAFF TRAINING

Staff training is an integral part of all behavioral programs at NVTC. Pre-service training for all employees is conducted by Psychological Services to ensure that all individuals involved in the direct care of clients are provided with information and skills to effectively implement all behavioral programs.

In addition, all staff are trained on the behavioral programs of each client before they are permitted to implement their programs. This training is competency based, i.e., staff must verbally describe the prescribed treatment plans, pass written tests, and demonstrate the techniques used in both the training and reactive components of the program.

Staff are then retrained on all clients' formal behavioral programs at least every 6 months or whenever a significant aspect of the client's program is changed. In addition, on-going in-services and staff training/retraining are conducted on an as needed basis along with regular monitoring of program implementation and documentation to ensure both consistency and reliability.

The following is a topical outline of the information presented by Psychological Services to all developmental aides and other staff who interact directly with clients on a regular basis:

- I. Describing behavior and behavioral objectives
  - A. Ways in which behavior can be changed
    - 1. Acquire/improve skill
    - 2. Increase behavior
    - 3. Appropriate stimulus conditions
    - 4. Decrease/eliminate behavior
  - B. Assumptions of behavioral approach
  - C. Components of behavioral objectives
    - 1. Learner
    - 2. Target behavior
    - 3. Criterion
    - 4. Conditions
    - 5. Target date
  - D. Activity (critique goals, objectives, plans)
- II. Observing and recording behavior: Measurement
  - A. Steps in measuring behavior
    - 1. Identify target behavior
    - 2. Select observation method
      - a. continuous
      - b. interval

- c. time sample
    - d. test method
  - 3. Select recording method
    - a. frequency
    - b. duration
    - c. intensity
    - d. level of support
  - 4. Chart/graph data
- B. Phases in data collection
  - 1. baseline
  - 2. treatment
  - 3. follow-up

### III. Increasing behaviors: Reinforcers

- A. Types of consequences
- B. Types of reinforcers
  - 1. Edibles
  - 2. Social
  - 3. Manipulable or activity
  - 4. Tokens
  - 5. Sensory
- C. Guidelines for use of reinforcers
  - 1. Immediacy
  - 2. Consistency
  - 3. "Bridging signal"
  - 4. "Natural" vs. "artificial"
  - 5. Minimum effective quantity
- D. Schedules of reinforcement
  - 1. Continuous
  - 2. Intermittent
- E. Identifying reinforcers
  - 1. Ask the person
  - 2. Observe the person
  - 3. Ask others
  - 4. Observe similar persons
  - 5. Reinforcer sampling

### IV. Teaching new behaviors

- A. Task analysis
- B. Chaining
  - 1. Backward
  - 2. Forward
- C. Prompting
  - 1. Verbal
  - 2. Gestural
  - 3. Imitative
  - 4. Physical
- D. Fading
- E. Shaping
- F. Graduated guidance
  - 1. Levels of graduated guidance
  - 2. Guidelines for use

- V. Teaching the right time/place
  - A. Stimulus control
  - B. Differential reinforcement

- VI. Decreasing/Eliminating behaviors
  - A. Reasons to decrease/eliminate
  - B. Steps in planning behavior programs
    - 1. Define target behavior
    - 2. Baseline
      - a. antecedents
      - b. consequences
      - c. setting(s)
      - d. function
    - 3. Develop plan - least restrictive treatment alternative
    - 4. Apply and measure impact
    - 5. Revise plan
  - C. Positive reductive procedures
    - 1. Differential reinforcement of other behavior
    - 2. Differential reinforcement of appropriate behavior
    - 3. Differential reinforcement of incompatible behavior
  - D. Other procedures
    - 1. Extinction
    - 2. Restitution
    - 3. Quiet room/area
    - 4. Restraint
    - 5. Overcorrection
  - E. Disadvantages of punishment
    - 1. Aggression
    - 2. Injury
    - 3. Time consumption
    - 4. Avoidance of punisher
    - 5. Emotional reactions

## VIII. DEFINITIONS

**Adaptive behavior:** That behavior which is considered appropriate for a given individual in a specific context. This term usually refers to behavior that is judged acceptable by professionals such as educators and service providers, and not in need of modification. These judgments are guided by developmental and societal norms.

**Aversive conditioning:** The application, contingent upon the exhibition of maladaptive behavior, of intentionally startling, unpleasant or painful stimuli, or stimuli that have a potentially noxious effect.

**Behavior management:** Procedure to increase adaptive behaviors and to modify maladaptive or problem behaviors and replace them with behaviors that are adaptive and socially acceptable.

**Behavior Management Committee:** A committee responsible for the periodic review and approval of behavioral programs. The committee includes (a) persons qualified to evaluate published behavior management research studies and the technical adequacy of proposed behavior management interventions, and (b) a physician, pharmacist, or other professional qualified to evaluate proposals for the use of drugs to manage behavior.

**Emergency procedures:** The use of procedures necessary to manage severely aggressive or destructive behaviors that place the individual or other in imminent danger when those behaviors reasonably could not have been anticipated.

**Maladaptive behavior:** Those behaviors judged as inappropriate or ineffective in a given context, such as a residential living environment or a work site. In general, such behaviors interfere with a client's learning or social interaction and leads to discomfort.

**Mechanical restraint:** The use of mechanical devices to restrict the movement of normal functioning of a portion of an individual's body. Examples of this method include helmets, arm splints, posey mittens, posey vests, seatbelt, wrist cuffs, and 4-point bed restraint.

**Personal restraint:** The use of manual methods to restrict the movement of normal functioning of a portion of an individual's body. At NVTC, the graduated approach to the use of physical interaction procedures described by the Mandt System will be used. If these physical restraint procedures have been demonstrated to be ineffective, then approved modifications must be written into the client's behavioral program.

**Physical restraint:** The use of manual methods or mechanical devices that are intended to restrict the movement of normal functioning of a portion of an individual's body.

**Psychotropic medication:** Medications usually prescribed and administered to individuals with a psychiatric diagnosis (or symptoms) for the purpose of modifying the maladaptive behavior of an individual. Examples include antidepressants, stimulants, and major and minor tranquilizers.

**Restrictive behavioral program:** The use of psychotropic medication, restraints, locked time-out, and modification of client's rights are considered as restrictive procedures at NVTC. Certain other procedures, as specified in the Summary of Programmatic Uses of Restrictive Procedures, are also restrictive under certain situations.

**Seclusion:** The noncontingent placement of an individual alone in a room or other area from which egress is prevented. This does not include placement in a time-out room as part of a behavior management program that meets all applicable standards.

**Time-Out:** An enclosed area in which the individual is placed contingent upon the exhibition of a maladaptive behavior, in which reinforcement is not available, and from which egress is denied until appropriate behavior is exhibited.



## IX. APPENDIX

- A. Mission and Goals of NVTC
- B. Mission statement for the Behavior Management Committee
- C. Local Human Rights Committee
- D. Functional Analysis Interview Form
- E. Crisis Management Documentation Form
- F. Behavior Program Record
- G. Monthly Review of Restrictive and Nonrestrictive Behavior Program
- H. BMC/LHRC Update Sheet
- I. Group Active Treatment Outcome Monitoring Form
- J. Psychotropic Medication Assessment
- K. The Mandt System
- L. List of Approved Mechanical Restraint Devices

DATE REVIEWED: 2/23/03

**INSTRUCTION:** Use each succeeding line when the INTERVENTION PROCEDURE changes from (1) a nonrestrictive to restrictive or (2) a restrictive to another restrictive procedure.

| DATE | SMT | START | TIME (in minutes) |     | DRTN | ANTCS<br>(below) | MAL ADAPTIVE<br>BEHAVIOR | BEHAVE<br>IN INST | INTERVENTION  | STAFF<br>INITIAL | Program Implementation |     |     |    |    | TARGETED MAL ADAPTIVE BEHAVIORS |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |    |
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|      |     |       | CHCK              | END |      |                  |                          |                   |               |                  | Mod                    | Doc | Trn | Ad | Pr | St                              | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |    |
|      | PM  |       |                   |     |      |                  | ABCDEFGHI                | 12345             | 1234567891011 |                  |                        |     |     |    |    |                                 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | </ |

PRECIPITATING CONDITIONS AND/OR ANTECEDENTS TO MALADAPTIVE BEHAVIORS

1. Environment - Noisy/Crowded/Active
2. No Activity Offered or Available to Client
3. Illness/Pain/Discomfort/Deprivation
4. Annoyed/Attit by Another Client
5. Refusal/Denial of a Client's Request
6. Ignored or Lack of Attention
7. Reprimanded or Criticized
8. Stopped from Doing Something
9. Doing New or Difficult Task

- 10 During Easy or Routine Task
- 11 Disruption of Daily Routine
- 12 Return from Home/Community
- 13 Violation of Personal Space
- 14 Request - Transition to Another Area
- 15 Request - Perform Self-care
- 16 Request - Structured Training
- 17 Request - Sit down, Wait, Stop, etc
- 18 Request - Others

19. Other (specify) \_\_\_\_\_  
20. Other (specify) \_\_\_\_\_  
21. Other (specify) \_\_\_\_\_

## OPERATIONAL DEFINITIONS

Agitation - Eyes dilated, red mucos, phosus slipping, abd physical movements, hyperreflexia  
ventilator use

**Aggravation to People - hitting, kicking, punching, pinching, wounding, etc.**

SIB - Involvement, pushing, pulling, etc.

DATA SUMMARY SHEET MAINTAINING BEHAVIORS & CONSEQUENCES

Name: [REDACTED]

REG # 745

UNIT: SUU

Year: 1999

|     | Frequency Maladaptive Behaviors |    |    |    |    |    | Non-Physical<br>Methods |     | OR/QA/R<br>Rebuke |     | Time Out |     | Physical<br>Methods |     | St on Mat |     | Self-Restraint |     | 2 points |     | C- Site<br>Calm |     | Crisis<br>Management |     | Program<br>Extension |     | Chemical<br>Intervention |     | TOT EPISODES |     |
|-----|---------------------------------|----|----|----|----|----|-------------------------|-----|-------------------|-----|----------|-----|---------------------|-----|-----------|-----|----------------|-----|----------|-----|-----------------|-----|----------------------|-----|----------------------|-----|--------------------------|-----|--------------|-----|
| AM  | A                               | B  | C  | D  | E  | F  | FHQ                     | DUM | FHQ               | DUM | FHQ      | DUM | FHQ                 | DUM | FHQ       | DUM | FHQ            | DUM | FHQ      | DUM | FHQ             | DUM | FHQ                  | DUM | FHQ                  | DUM | FHQ                      | DUM | FHQ          | DUM |
| Jan | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Feb | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Mar | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Apr | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| May | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Jun | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Jul | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Aug | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Sep | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Oct | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Nov | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Dec | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| PM  | A                               | B  | C  | D  | E  | F  | FHQ                     | DUM | FHQ               | DUM | FHQ      | DUM | FHQ                 | DUM | FHQ       | DUM | FHQ            | DUM | FHQ      | DUM | FHQ             | DUM | FHQ                  | DUM | FHQ                  | DUM | FHQ                      | DUM | FHQ          | DUM |
| Jan | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Feb | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Mar | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Apr | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| May | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Jun | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Jul | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Aug | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Sep | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Oct | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Nov | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| Dec | 11                              | 11 | 11 | 11 | 11 | 11 | 11                      | 11  | 11                | 11  | 11       | 11  | 11                  | 11  | 11        | 11  | 11             | 11  | 11       | 11  | 11              | 11  | 11                   | 11  | 11                   | 11  | 11                       | 11  | 11           | 11  |
| NOC | A                               | B  | C  | D  | E  | F  | FHQ                     | DUM | FHQ               | DUM | FHQ      | DUM | FHQ                 | DUM | FHQ       | DUM | FHQ            | DUM | FHQ      | DUM | FHQ             | DUM | FHQ                  | DUM | FHQ                  | DUM | FHQ                      | DUM | FHQ          | DUM |
| Jan | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Feb | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Mar | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Apr | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| May | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Jun | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Jul | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Aug | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         | 1   | 1              | 1   | 1        | 1   | 1               | 1   | 1                    | 1   | 1                    | 1   | 1                        | 1   | 1            | 1   |
| Sep | 1                               | 1  | 1  | 1  | 1  | 1  | 1                       | 1   | 1                 | 1   | 1        | 1   | 1                   | 1   | 1         |     |                |     |          |     |                 |     |                      |     |                      |     |                          |     |              |     |

Program Changes:

BEHAVIORS  
A Agitation (1.2.3.4)  
B Aggression to People (2.3.4)  
C SM (2.3.4)

PHOTO

Name: [REDACTED]

REG #: 745

UNIT: SMU

Year: 1994

Use /range across for columns not used. Do not use the shading because it takes up too much disk space.

| Total<br>UNIT | Frequency Maladaptive Behaviors |   |   |   |   |   | Non-Physical<br>Mand |     | QA/QA/BR<br>Residue |     | Time Out |     | Physical<br>Mand |     | St on Mat |     | Self-Restrain |     | 2 points |     | C-SM<br>Calm |     | Crisis<br>Management |     | Program<br>Extension |     | Chemical<br>Intervention |     | TOTAL EPISODES |     |
|---------------|---------------------------------|---|---|---|---|---|----------------------|-----|---------------------|-----|----------|-----|------------------|-----|-----------|-----|---------------|-----|----------|-----|--------------|-----|----------------------|-----|----------------------|-----|--------------------------|-----|----------------|-----|
|               | A                               | B | C | D | E | F | FREQ                 | DUR | FREQ                | DUR | FREQ     | DUR | FREQ             | DUR | FREQ      | DUR | FREQ          | DUR | FREQ     | DUR | FREQ         | DUR | FREQ                 | DUR | FREQ                 | DUR | FREQ                     | DUR | FREQ           | DUR |
| Jan           | 12                              | 7 | 6 | 0 | 0 | 0 | 4                    | 51  | 0                   | 0   | 0        | 0   | 0                | 0   | 0         | 01  | 7             | 02  | 4        | 70  | 2            | 52  | 0                    | 0   | 0                    | 0   | 0                        | 0   | 15             | 331 |
| Feb           | 7                               | 1 | 3 | 0 | 0 | 0 | 4                    | 37  | 0                   | 0   | 0        | 0   | 0                | 0   | 2         | 16  | 1             | 12  | 2        | 35  | 2            | 33  | 0                    | 0   | 0                    | 0   | 0                        | 0   | 7              | 134 |
| Mar           | 2                               | 0 | 0 | 0 | 0 | 0 | 2                    | 6   | 0                   | 0   | 0        | 0   | 0                | 0   | 1         | 8   | 0             | 0   | 0        | 0   | 0            | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 2              | 12  |
| Apr           | 6                               | 4 | 7 | 0 | 0 | 0 | 6                    | 44  | 0                   | 0   | 0        | 0   | 0                | 0   | 6         | 66  | 1             | 15  | 3        | 85  | 1            | 15  | 0                    | 0   | 0                    | 0   | 0                        | 0   | 14             | 276 |
| May           | 8                               | 0 | 3 | 0 | 0 | 0 | 6                    | 42  | 0                   | 0   | 0        | 0   | 0                | 0   | 8         | 37  | 2             | 3   | 2        | 73  | 1            | 7   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 6              | 162 |
| Jun           | 7                               | 0 | 1 | 0 | 0 | 0 | 5                    | 54  | 0                   | 0   | 0        | 0   | 0                | 0   | 6         | 36  | 2             | 16  | 0        | 0   | 0            | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 8              | 106 |
| Jul           | 21                              | 5 | 4 | 0 | 0 | 0 | 13                   | 76  | 0                   | 0   | 0        | 0   | 0                | 0   | 16        | 160 | 7             | 66  | 4        | 82  | 0            | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 22             | 416 |
| Aug           | 10                              | 1 | 5 | 0 | 0 | 0 | 6                    | 44  | 0                   | 0   | 0        | 0   | 0                | 0   | 6         | 35  | 2             | 14  | 0        | 0   | 0            | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 10             | 93  |
| Sep           | 5                               | 1 | 3 | 0 | 0 | 0 | 2                    | 30  | 0                   | 0   | 0        | 0   | 0                | 0   | 2         | 10  | 1             | 8   | 0        | 0   | 1            | 6   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 6              | 54  |
| Oct           | 16                              | 2 | 3 | 0 | 0 | 0 | 2                    | 2   | 2                   | 20  | 0        | 0   | 0                | 0   | 6         | 27  | 6             | 45  | 2        | 42  | 0            | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 10             | 142 |
| Nov           | 2                               | 0 | 1 | 0 | 0 | 0 | 2                    | 20  | 0                   | 0   | 0        | 0   | 0                | 0   | 1         | 6   | 1             | 12  | 0        | 0   | 0            | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 2              | 37  |
| Dec           | 10                              | 1 | 6 | 0 | 0 | 0 | 6                    | 42  | 1                   | 12  | 0        | 0   | 0                | 0   | 6         | 112 | 6             | 90  | 1        | 16  | 0            | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 6              | 285 |

STC

|     |   |   |   |   |   |   |   |    |   |   |   |   |   |   |   |    |   |    |   |    |   |   |   |   |   |   |   |   |    |     |
|-----|---|---|---|---|---|---|---|----|---|---|---|---|---|---|---|----|---|----|---|----|---|---|---|---|---|---|---|---|----|-----|
| Jan | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0   |
| Feb | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0   |
| Mar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0   |
| Apr | 1 | 0 | 1 | 0 | 0 | 0 | 2 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2  | 14  |
| May | 3 | 1 | 0 | 0 | 0 | 0 | 3 | 71 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 1 | 2  | 1 | 32 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3  | 103 |
| Jun | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0   |
| Jul | 7 | 3 | 4 | 0 | 0 | 0 | 6 | 23 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 35 | 4 | 40 | 1 | 45 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7  | 152 |
| Aug | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0   |
| Sep | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 20 | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 20 | 0   |
| Oct | 2 | 0 | 1 | 0 | 0 | 0 | 2 | 32 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 10 | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 42 | 0   |
| Nov | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 33 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 6  | 0 | 0  | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 36 | 0   |
| Dec | 3 | 0 | 2 | 0 | 0 | 0 | 3 | 32 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 16 | 1 | 25 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 73 | 0   |

Program Changes:

BEHAVIORS: A Agitation (1,2,3,5)  
B Aggression to People (2,3,4)  
C SB (2,3,4)

ID

# DATA SUMMARY SHEET: ADAPTIVE BEHAVIORS

CLIENT:                       
REG #: 745

UNIT: 5

YEAR: 1994

| MONTH     | ADAPTIVE<br>BEHAVIORS<br>PER PROBE | COMPLIANCE<br>CUMULATIVE PERCENT |      |       |        | # TRIALS | OTHER |  |  |
|-----------|------------------------------------|----------------------------------|------|-------|--------|----------|-------|--|--|
|           |                                    | 1 VP                             | 2 VP | 3 VP  |        |          |       |  |  |
| JANUARY   | 14.25                              | 1.67                             | 83   | 98    | 100    | 239      |       |  |  |
| FEBRUARY  | 32.75                              | 7.44                             | 93   | 100   |        | 215      |       |  |  |
| MARCH     | 38.8                               | 14.4                             | 94   | 99    | 100    | 238      |       |  |  |
| APRIL     | 36.75                              | 16.7                             | 94   | 97    | 99.57  | 233      |       |  |  |
| MAY       | 34.75                              | 0.82                             | 85   | 96    | 99     | 244      |       |  |  |
| JUNE      | 32.75                              | 2.04                             | 86   | 96    | 100    | 196      |       |  |  |
| JULY      | 34.3                               | 5.8                              | 90   | 92    | 97     | 223      |       |  |  |
| AUGUST    | 33.8                               | 0.82                             | 83   | 95    | 100    | 243      |       |  |  |
| SEPTEMBER | 28                                 | 1.29                             | 86   | 99.57 | NO 3's | 232      |       |  |  |
| OCTOBER   | 28.67                              | 0                                | 87   | 97    | 99     | 231      |       |  |  |
| NOVEMBER  | 25.2                               | 3.1                              | 73   | 94    | 99.56  | 228      |       |  |  |
| DECEMBER  | 28.75                              | 7                                | 90   | 97.5  | 99.59  | 242      |       |  |  |

TARGETED ADAPTIVE BEHAVIORS:

TYPES OF REINFORCERS:

PROGRAM CHANGES:

NORTHERN VIRGINIA TRAINING CENTER  
FOR THE MENTALLY RETARDED

Medical Plan for Psychotropic Drug Use

Name: [REDACTED] Unit: 6 DOB: 06/17/46 REG NO: 000745

**History of Psychotropic Drug use and Previous Behavioral Procedures Tried:**

[REDACTED] has been on a variety of psychotropic medication over the years. Most recently, he has been treated with a combination of Lithium and Tegretol. In the past, when he was a teenager, there were several trials of neuroleptic medication that allegedly led to a severe tardive dyskinesia. For these reasons, since he was a teenager, neuroleptic medication has never been prescribed again. Unfortunately, [REDACTED] often appears quite psychotic and the manifestations of his psychosis are not helped much by the prescription of Lithium and Tegretol.

**Name of Psychotropic Drug, Frequency, Dosage, Route of Administration and Plans to Achieve Therapeutic Level:**

The medication to be tried is Clozapine up to a dosage of 900 mg daily. This medication has been tried in Europe for the past 20 years and found not to cause extrapyramidal symptoms or tardive dyskinesia.

**Target Maladaptive Behavior to be modified:**

Other: Self-abuse, physical aggression, disruptive behavior

Monthly Frequencies: See Psychologist's notes.

| Month | Total | Month | Total |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Name of Psychiatric Consultant: Dr. Howard I. Pressman

**List of Potential Side Effects of the Psychotropic Drug:**

a) Major Side Effects:

Agranulocytosis, hypotension, seizures

b) Minor Side Effects:

Constipation, dizziness, fever, hypertension, sedation, salivation, tachycardia, and weight gain

**Medical Review of Side Effects (by whom, frequency, outcome of review) including Laboratory Work if Indicated:**

Secondary to the possibility of agranulocytosis, anyone who takes Clozaril must be monitored, under the Clozaril monitoring system. This includes a weekly white count and differential, which is reviewed by the prescribing physician and pharmacist before the medication then can be prescribed. In addition, other side-effects will be monitored by unit staff, unit nurses, the unit physician, and consulting psychiatrist.

Medical Plan for Psychotropic Drug Use

Plans to be Implemented in the Event of Side Effects:

In the event of signs or symptoms of agranulocytosis, the Clozaril will be immediately discontinued and [redacted]'s white count will be monitored daily. Other side-effects are dealt with by dosage reduction or change in timing of dosage prescription.

Statement Regarding Resident's Harmful and Undesirable Behavior Overweighing the Drug's Potential Harmful Side Effects:

It is the opinion of this psychiatrist that the [redacted]'s undesirable behavior outweighs the potential harmful side effects of Clozaril.

Concurrent behavior Programs (if any) Designed by the Interdisciplinary Team for the Target behavior: Psychologist's section

See activity schedules for the reinforcing environments.

See behavioral plans of the target behaviors \_\_\_\_\_

(See section 5)

Medical Plans, including Objective for Review based on Available Collected Behavior Charts including Review Frequency, how documented and if possible, Plan for Readjusting, Reducing or Discontinuing the Drug:

Psychotropic medication reviews will continue, as they always have, on a weekly basis. Specific data will be collected and presented at the weekly reviews and then decisions made about the dosage of medication. In the event of lack of response, the medication will be gradually decreased and discontinued.

Signed: Howard I. Pressman, M.D.  
Consulting Psychiatrist

Date: 11/15/93

CONSENTS:

By Resident:

a) Competent adult-consent signed ( ). Unable to make medical decisions (✓).

By Parent/Guardian:

- a) Psychiatry conference attended and verbal consent given ( ).
- b) Consent given by telephone (✓).
- c) Consent given in writing (✓).

APPROVAL:

By Interdisciplinary Team: [Signature]

Date: 10-15-93

By Psychologist: [Signature]

Date: 11/15/93

BMC Approval: [Signature]

Date: 10/18/93

LHRC Approval: \_\_\_\_\_

Date: \_\_\_\_\_

Submitting Attending Physician: [Signature]

Date: 11/15/93

Oct. 18, 1993

Over Telephone, Approved by

LHRC: Mrs. Claire Jacques,

Mrs. Ann Sale

Mr. James Tiernan

[Signature]

NORTHERN VIRGINIA TRAINING CENTER

PERMISSION FOR ADMINISTRATION OF MEDICATION

I hereby give consent to Northern Virginia Training Center medical staff to administer to:

the medication:

Clozapine

The following adverse conditions which may occur as a result of the prescribed medication are listed below and have been explained to you by:

a) Major Side Effects:

Agranulocytosis, hypotension, seizures

b) Minor Side Effects:

Constipation, dizziness, fever, hypertension, sedation, salivation, tachycardia, and weight gain

I have been fully informed of the nature of the above medication, potential side effects and the reason for the use of the medication. I understand I can withdraw my consent at any time.

Signed: David M. L...

Relationship: John Mad...

Grandson

Date: 10-18-93

Witness: John M. L...

Date: 10-18-93



INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO \_\_\_\_\_)

| Date    | Target Behaviors Status                     | Prescribed Medications Dosage/Signature                                  | Physician's Comments                                                | Adverse Reactions                       |
|---------|---------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------|
| 8/10/94 | Severe agitation 2/0<br>Agg. 1/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Plan to meet with [unclear]                                         |                                         |
| 8/17/94 | Severe agitation 1/0<br>Agg. 0/0<br>SIB 1/0 | LiCO <sub>3</sub> 200-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Pretty good week.                                                   |                                         |
| 8/24/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Stable                                                              |                                         |
| 8/31/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Good to see [unclear]                                               |                                         |
| 9/7/94  | Severe agitation 1/0<br>Agg. 0/0<br>SIB 1/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Stable                                                              |                                         |
| 9/14/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Flight, very involved in all activities, handling frustration well. | Speech & [unclear] when he is agitated. |
| 9/21/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Stable                                                              |                                         |
| 9/28/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. P. [Signature] | Doing well                                                          |                                         |

Department of Mental Health, Northern Virginia Training Center  
Restoration and Substance Abuse Services  
INTERDISCIPLINARY NOTES  
All entries must be signed with name, title, and discipline. Use black ink.

ADDRESSOGRAPH  
745  
NVTC 6MB  
VH/M DOB 6-18-55  
FAX 1-7-86  
227-74-5883

INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO. \_\_\_\_\_)

| Date     | Target Behaviors Status                          | Prescribed Medications Dosage/Signature                                | Physician's Comments                                                                                          | Adverse Reactions |
|----------|--------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------|
| 10/15/94 | Severe agitation 50%<br>Aggression 0%<br>SIB 10% | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Constant perseveration, flumin constant reassurance. Can be directed easily though.                           |                   |
| 10/12/94 | Severe agitation 20%<br>Agg. 0%<br>SIB 10%       | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Did well at camp. Such after camp - when he had the episode.                                                  |                   |
| 10/19/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Complained over post code.                                                                                    |                   |
| 10/22/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Continued to be aggressive and disruptive. No improvement in behavior. Still needs structure and supervision. |                   |
| 10/26/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Continued to be aggressive and disruptive. No improvement in behavior. Still needs structure and supervision. |                   |
| 11/02/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Continues to be aggressive and disruptive. No improvement in behavior. Still needs structure and supervision. |                   |
| 11/09/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Continues to be aggressive and disruptive. No improvement in behavior. Still needs structure and supervision. |                   |
| 11/16/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Continues to be aggressive and disruptive. No improvement in behavior. Still needs structure and supervision. |                   |
| 11/23/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Continues to be aggressive and disruptive. No improvement in behavior. Still needs structure and supervision. |                   |
| 11/30/94 | Severe agitation 0%<br>Agg. 0%<br>SIB 0%         | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Pashman, M.D. | Continues to be aggressive and disruptive. No improvement in behavior. Still needs structure and supervision. |                   |

Department of Mental Health Services  
Mental Health and Substance Abuse Services  
Northern Virginia Training Center  
INTERDISCIPLINARY NOTES

All entries must be signed with name, title, and discipline. Use black ink.

ADDRESSOGRAPH

INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO \_\_\_\_\_)

| Date     | Target Behaviors Status                   | Prescribed Medications Dosage/Signature                                | Physician's Comments                                                                          | Adverse Reactions |
|----------|-------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------|
| 1/1/94   | Summary of Feb 2/2                        | LiCO <sub>3</sub> 300-300-600                                          | Difficult sleeping at night - will remain about morning for another week. Sleepers now sleep. |                   |
| 2/14/94  | Agg. 0/0<br>SIB 0/2                       | Clonidine 150-250<br>H. Parnham, M.D.                                  |                                                                                               |                   |
| 2/26/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. | More episodes and food related and related to expectations.                                   |                   |
| 3/1/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. | Some 2 ago patient went to work without. Concern about inappropriate attention at work.       |                   |
| 3/15/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 3/22/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 3/29/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 4/5/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 4/12/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 4/19/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 4/26/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 5/3/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 5/10/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 5/17/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 5/24/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 5/31/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 6/7/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 6/14/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 6/21/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 6/28/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 7/5/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 7/12/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 7/19/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 7/26/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 8/2/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 8/9/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 8/16/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 8/23/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 8/30/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 9/6/94   | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 9/13/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 9/20/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 9/27/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 10/4/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 10/11/94 | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 10/18/94 | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 10/25/94 | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
| 11/1/94  | Summary of Feb 2/2<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clonidine 150-250<br>H. Parnham, M.D. |                                                                                               |                   |
|          |                                           |                                                                        |                                                                                               |                   |

**Department of Mental, Health, and Substance Abuse Services**

Northern Virginia: The Village Center

INTERDISCIPLINARY NOTES

ALL entries must be signed with name, title,  
and discipline. Use black ink.

**ADDRESS ONLY**

INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO

[illegible]

Northern Virginia Training Center

## INTERDISCIPLINARY NOTES

All entries must be signed with name, title, and discipline. Use black ink.

| 1995                                                                                          | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
|-----------------------------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| <b>NEUROLOGY</b><br>Tues, 2x mo<br>1 pm<br>Jecker 352-6996                                    |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>ENT</b><br>4th Thurs/mo<br>9:30 am<br>Dr. Rooney 281-2266                                  |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>ORTHOPEDIC</b><br>3rd Fri/mo<br>1:00 pm<br>Dr. Rogers 998-1110                             |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>OPHTHALMOLOGY</b><br>4th Tues q2 mo<br>2:30 pm / 1:30 eye drops<br>Dr. Forster FC 534-3900 |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>PHYSIATRY</b><br>Mon q2 mo<br>9:30 am<br>Dr. Gashi 938-5744                                |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>GI</b><br>last Monday q2 mo<br>9:30 am<br>Dr. Fischer 860-1700                             |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>PODIATRY</b><br>Monday q mo<br>pm<br>Greiner 941-7770                                      |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>UROLOGY</b><br>Last Wed q2 mo<br>1:00 pm<br>Dr. Glover 591-5443                            |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>CARDIOLOGY</b><br>2nd Mon q3 mo<br>9:00 am<br>Dr. Singh 591-7770                           |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>GYNECOLOGY</b><br>3rd Mon q3 mo<br>9:30 am<br>Dr. Leary 281-5000                           |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>DERMATOLOGY</b><br>3rd Thurs q3 mos<br>9:30 am<br>Dr. Silverman 641-0083                   |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>ALLERGY</b><br>3rd Thurs q3 mo<br>9:30 am<br>Dr. Schuster 689-2000                         |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>GENETIC</b><br>Loosenbaum (202)8842187                                                     |     |     |     |     |     |     |     |     |     |     |     |     |

ATTACHMENT

NORTHERN VIRGINIA TRAINING CENTER  
BEHAVIOR INTERVENTION PROGRAM  
APPROVAL/SIGNATURE SHEET

Name: \_\_\_\_\_ Reg#: 745 DOB: 06/18/63  
Residential Unit: 6 Date of Admission: 01/07/86

Problem #4: Needs to reduce aggression.

Program Goals: ~~\_\_\_\_\_~~ will have no more than 5 episodes of aggression to people per month for 3 consecutive months.

Program Title: Treatment of severely aggressive behaviors through the use of Clozapine and behavioral management procedures.

Responsible Staff: Tad Uno, Ph.D., Psychologist, Building 6

Approvals:

Ulla Marie Gomez, QMRP  
Interdisciplinary Team (QMRP)

Interim Approval Final Approval

Lamine Khusen  
Peer Review Committee (Chair)

Interim Approval Final Approval

Andrzej  
Psychologist

Interim Approval Final Approval

Andrzej  
Director of Psychology

Interim Approval Final Approval

Dr. S. S. S.  
Physician

Interim Approval Final Approval

William A. S.  
Dietitian

Interim Approval Final Approval

Mr. Smith  
Parent/Guardian

Interim Approval Final Approval

David H. S.  
BMC

Interim Approval Final Approval

Colleen S.  
LHRC

Interim Approval Final Approval

Mark S.  
Advocate

Notification Notification

David H. S.  
Director

Interim Approval Final Approval

NORTHERN VIRGINIA TRAINING CENTER  
BEHAVIOR INTERVENTION PROGRAM  
BEHAVIORAL OBJECTIVES

Name: ~~XXXXXXXXXXXX~~  
Residential Unit: 5

Reg#: 745

DOB: 06/18/63

Date of Admission: 01/07/86

**Problem #4:** Needs to reduce aggression.

Program Goals: [REDACTED] will have no more than 5 episodes of aggression to people per month for 3 consecutive months.

**Relevant Strengths:** Friendly; inquisitive; desire to please, learn, and succeed; able to ask for assistance; good expressive and receptive verbal communication skills (but may be difficult to understand at times); reads, writes, and do arithmetic problems at approximately the 2nd/3rd grade levels; relatively social and initiates interactions with others; interested in his health care needs; responsive to staff praise and attention; good short and long-term memory; many leisure and recreational skills & interests; understands value of money; usually cooperative; and initiates interactions.

Program Title: Treatment of severely aggressive behaviors through the use of Clozapine and behavioral management procedures.

### Objectives:

1/36 05/16/94 [REDACTED] will receive at least 30 reinforcements per probe for adaptive behaviors each month for 6 consecutive months, by 06/01/95.

Psychologist: James H. [Signature]  
Date met: \_\_\_\_\_

1/37      12/28/94      [REDACTED] will have no more than 1 episode of aggression to people each month for 3 consecutive months by 12/01/95.

Psychologist: W. L. ...  
Date Met: \_\_\_\_\_

NORTHERN VIRGINIA TRAINING CENTER  
PSYCHOLOGICAL SERVICES  
BEHAVIOR INTERVENTION PROGRAM

Name: [REDACTED] Reg#: 745 DOB: 06/13/65  
Residential Unit: 5 Date of Admission: 01/07/86

Problem #4: Needs to reduce aggression.

Program Goals: [REDACTED] will have no more than 5 episodes of aggression to people per month for 3 consecutive months.

Relevant Strengths: Friendly; inquisitive; desire to please, learn, and succeed; able to ask for assistance; good expressive and receptive verbal communication skills (but may be difficult to understand at times); reads, writes, and do arithmetic problems at approximately the 2nd/3rd grade levels; relatively social and initiates interactions with others; interested in his health care needs; responsive to staff praise and attention; good short and long-term memory; many leisure and recreational skills & interests; understands value of money; usually cooperative; and initiates interactions.

Program Title: Treatment of severely aggressive behaviors through the use of Clozapine and behavioral management procedures.

Responsible Staff: Tad Uno, Ph.D., Psychologist, Building 6

Trainers: All SBU and clinical staff involved in the provision of treatment and training to Ken.

Implementation Date: 9/23/94

I. DESCRIPTION OF CLIENT: The following program plans have been recopied numerous times since [REDACTED] was originally admitted to NVTC on 6/29/83, including the most recent revisions on 6/14/94. The current revision reduces the restrictiveness of his behavioral program by discontinuing the last contingent mechanical restraint procedure (i.e., 2-point wrist restraints) in 12/1994. In addition to the information provided below, more extensive background information and previous behavioral plans can be found in Resident Records.

A. Biographic/Diagnostic Characteristics: [REDACTED] is a mildly mentally retarded 29 year old man with a diagnosis of encephalopathy due to psychiatric disorder (Autism). [REDACTED] is also diabetic (diagnosed with juvenile diabetes in 10/83) and receives insulin almost on a daily basis.



1/03/95

~~NAME~~ was originally admitted to the Northern Virginia Training Center (NVTC) from DeJarnette Center for Human Development on 6/29/83. According to his parents, ~~NAME~~ experienced a severe toxic drug reaction to Haldol in 2/82 while at DeJarnette, resulting in tardive dyskinesia with concomitant loss of speech, incontinence, and behavioral regression to early infantile levels.

From 8/15/83 - 11/13/84, ~~NAME~~ resided on the Special Behavior Unit at Central Virginia Training Center (CVTC) because of his increased aggression and his residential Unit at NVTC to effectively manage his behavior. Because ~~NAME~~ continued to display psychotic-like behaviors as well as extremely aggressive behaviors to himself and others, he was transferred to NVMHI shortly after his return to NVTC, and then to Western State Hospital on 12/12/85. ~~NAME~~ returned to NVTC on 1/7/86, again relatively unchanged, and was admitted to the newly created NVTC Special Behavior Unit.

A wide variety of restrictive treatment programs have been used over the years to address ~~NAME~~'s maladaptive behaviors, including behavioral and psychopharmacological approaches. (For more detailed information, please refer to Section I-C below and written records filed in Resident Records).

At the present time, ~~NAME~~ is generally a friendly and social individual who readily initiates and sustains interactions with staff and appears to enjoy their attention (see above for additional developmental strengths). His self-care and community living skills are relatively well developed refinement in specific areas are needed (see Residential Services reports for additional information). His receptive verbal and expressive communications skills are relatively good (able to appropriately express his wants, needs, and refusals) although some slurring in his speech makes him difficult to understand at times. He frequently initiates independent leisure activities and particularly enjoys such activities as looking/reading magazines and books, writing and drawing, watching television, movies, foods and cooking, swimming, biking, walking, and Soccer, and visiting with family.

1/03/95

██████ has displayed a wide range of maladaptive behaviors in the past beginning in early childhood, including perseveration, oppositional behavior, inappropriate toileting, agitation, hallucinations, aggression to people and property, and self-injurious behaviors. However, since ██████ began receiving Clozapine in 10/93, he has shown a remarkable reduction in the frequency, intensity, and duration of these maladaptive behaviors. This improved behavior was maintained through 1994 and he continues to do well despite occasional occurrences these behaviors (see Figures on pages 5 and 6 for frequencies of targeted maladaptive behaviors and intervention procedures). As noted earlier, mechanical restraints have now been completely discontinued.

For additional background and psychosocial information, please refer to the admission information and annual staff reports filed in Resident Records.

8. Frequency/Duration/Intensity of Baseline/Comparative Data: ██████ behavior is under relatively good management at this time, relative to his behaviors prior to the beginning of Clozapine in 10/93, and his rate of targeted maladaptive behaviors is relatively low at this time.

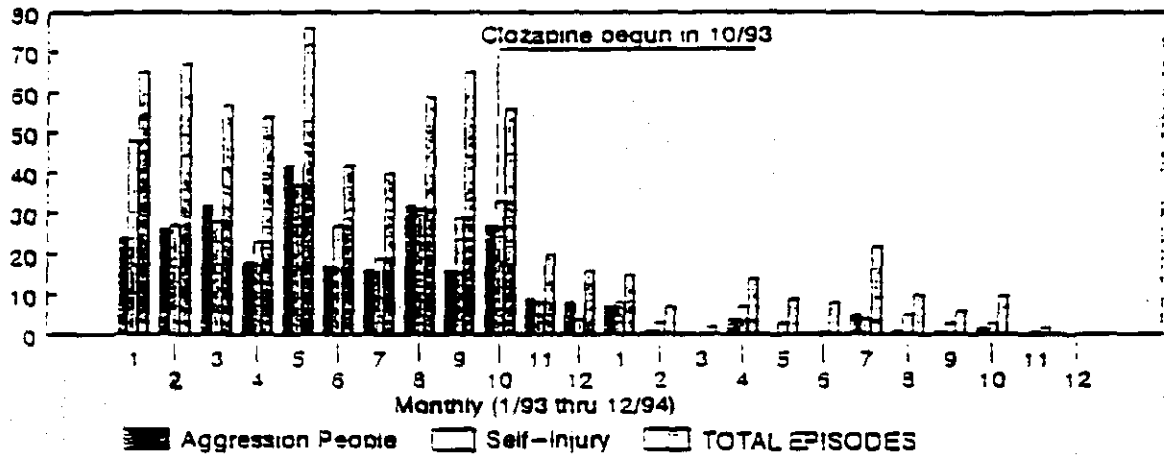
Baseline data from home or other treatment programs are not readily available prior to ██████ admission to NVTC. Since the rate of maladaptive behaviors have been relatively unchanged for the last several years beginning approximately a year following his most recent NVTC admission and prior to the start of Clozapine, data of specific maladaptive behaviors and intervention procedures collected during these latter years are graphically presented below and on pages 6 and 7. It should also be noted that the majority of the behavioral episodes consistently occur during the p.m. shift.

In addition, since many of his episodes include more than a single maladaptive behaviors and multiple interaction procedures, i.e., one behavior may merge into the next, the duration of each type of maladaptive behavior is not possible to determine. However, the average monthly duration of nonphysical and physical interactions are presented on page 7.

Additional intervention procedures used to assist in the management of aggressive behaviors have included program extensions (i.e., when a behavioral episode exceeds 60 minutes and additional time is required to achieve a state of calm) and emergency psychotropic medication. This information is presented on page 7.

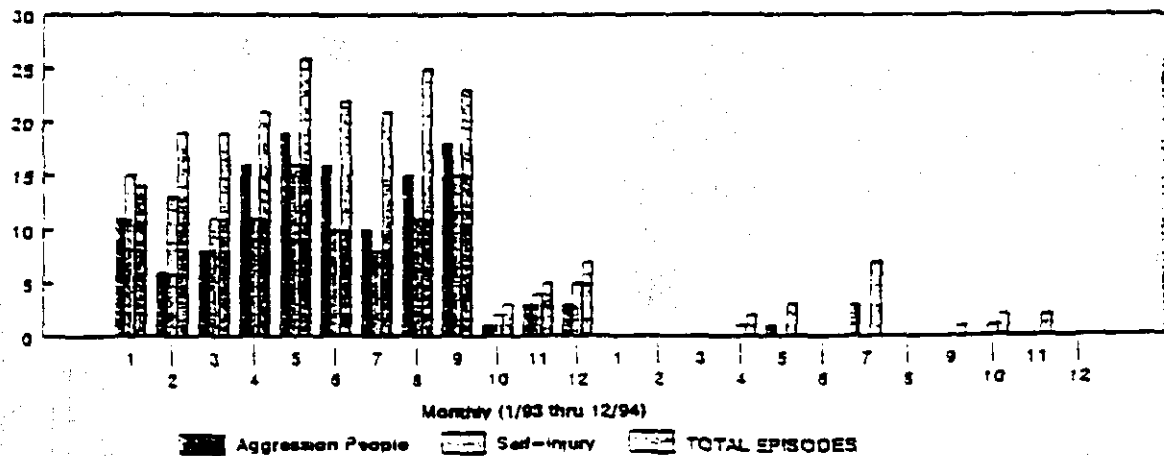
Targeted Maladaptive Behaviors: Unit

Frequency



Targeted Maladaptive Behaviors: STC

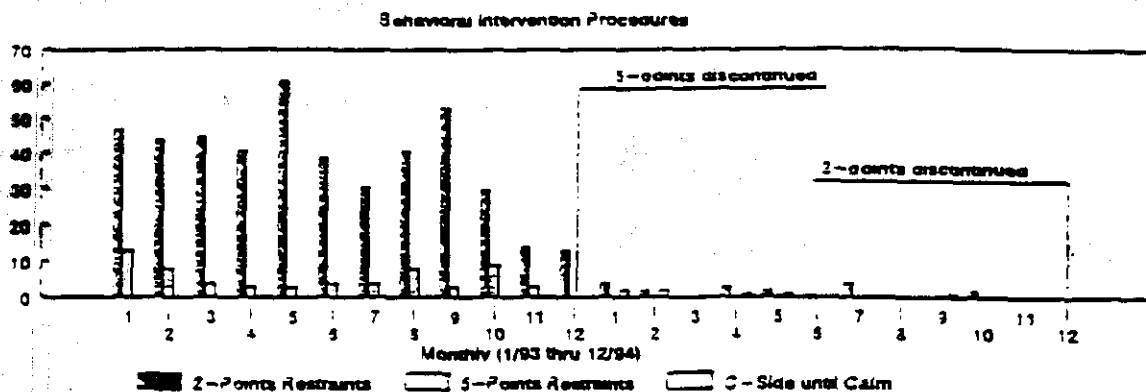
Frequency



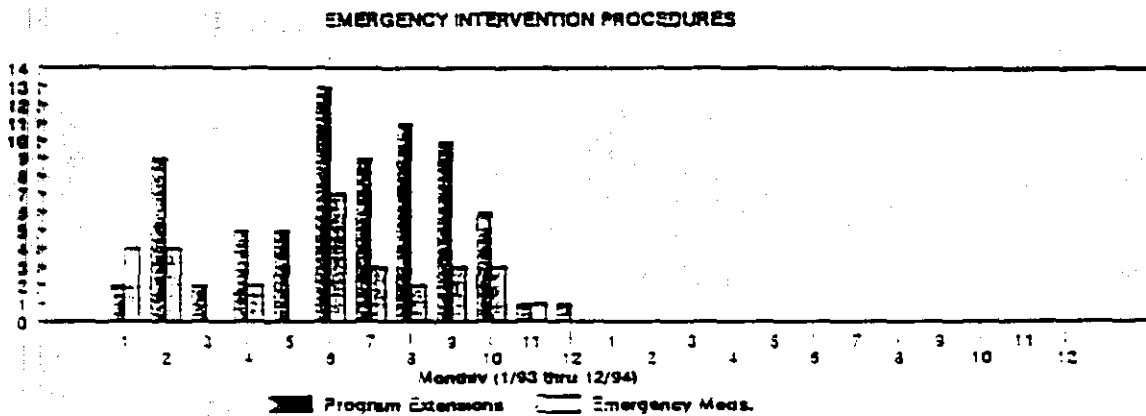
# **BEHAVIORAL INTERVENTION PROGRAM** **(Reg. #745)**

1/03/95

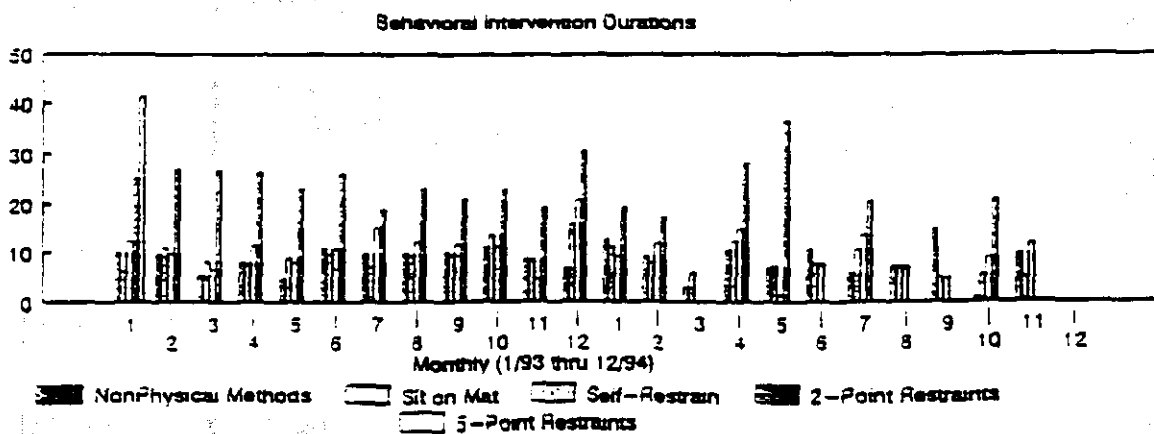
Frequency



Frequency



Time (in minutes)



The above rationale also applies to the determination of behavioral intensity for each targeted maladaptive behavior. The intensity of each episode of maladaptive behavior ranged from 1-5 (i.e., 1=low & 5=high) with an average of 4.0 per episode.

- C. Previous Interventions: ██████ has a history of maladaptive behaviors dating from early childhood. He has been enrolled in several residential and educational programs designed to address the needs of individuals with mental retardation who are also diagnoses with psychiatric disorders. A variety of training and intervention procedures have been tried to address his maladaptive behaviors, particularly his self-injurious and aggressive behaviors to others.

An assessment of previously used interventions suggests that the most effective program involved a combination of preventative, training, and reactive procedures which incorporated in vivo training and protective and calming procedures.

Training and reactive procedures which have been used in the past when ██████ became agitated or upset included problem-solving, verbal redirection, relaxation, and limit-setting. He has been on a token economy program, DRO for absence of aggressive behaviors, and social reinforcement for displaying appropriate/replacement/etc. behaviors using various DRI schedules.

When ██████ became aggressive, reactive procedures have included behavioral procedures (i.e., personal restraints, 2-point wrist restraints, 5-points supine bed restraints, and a "papoose board" as well as emergency psychotropic medications. At one point, ██████ aggression rate was so high (i.e., almost continuous at times) that medical orders were written to remove him from the other clients on his Unit and place him in 4-point bed restraints for extended periods of time. On many occasions, ██████ would have difficulty calming down within 60 minutes and program extensions have been required. For a graphic display of various intervention procedures used over the past two years, please refer to the preceding graph.

A behavior which has not been displayed since approximately 1989 is running away from wherever he happened to be, e.g., home or NVTC. Because of potential health issues associated with his diabetic condition, (1) [REDACTED] was always accompanied by staff whenever he was off the Unit, (2) an educational program was implemented to teach [REDACTED] what foods he should and should not eat, the health consequences of eating the wrong foods, the need for insulin, etc., and (3) a 24 hour Unit restriction whenever [REDACTED] left the Unit without staff permission. The only component remaining to the above plans at this time involves his dietary needs.

## II. FUNCTIONAL ANALYSIS:

Based on a review of [REDACTED] written records prior to his admission to NVTC (e.g., home, DeJarnette, CVTC, Western State Hospital, etc.), staff reports, personal observations, and an examination of his behavioral data, his maladaptive behaviors appear to be motivated by a combination of factors.

- A. **Psychiatric Diagnosis:** The large majority of [REDACTED] behaviors appear to be motivated by conditions associated with his diagnosis. He is a relatively nervous and anxious individual who appears to have many autistic-like behaviors. According to a 10/16/89 psychiatric evaluation, [REDACTED] "... suffers from autism. He manifests the classical triad of severely impaired interpersonal relationships, severe impairments of ability to communicate effectively, and a rigid repertoire of abilities to interact in the world." His current diagnosis is: Axis I - Autism; Axis II - Mild Mental Retardation; and Axis III - Diabetes. See records in Resident Records for previous diagnoses.
- B. **Sensory Stimulation:** Many of his infrequent Self-injurious behaviors (SIB) are reported to occur when appears to be having a relatively good day, is alone (usually in his bedroom or bathroom, and with no clear antecedent conditions).
- C. **Attention:** Agitation and aggression may occur when his repeated attempts to attract staff attention are unsuccessful.

- D. **Escape/Avoidance:** There have been times when ██████ have engaged in aggression, either to staff or himself, as a way of telling staff he prefers not to participate in negotiable (i.e., voluntary) or non-negotiable staff requests (i.e., requests for health and safety reasons).
- E. **Interruption of on-going activities:** Occasionally, ██████ may become upset when he is engaged in a preferred activity and does not want to stop, whether it is a recreational or vocational activity.

### III. DESCRIPTION OF TARGETED BEHAVIORS:

#### A. Definition:

- 1. Inappropriate Urination - Intentionally urinating in inappropriate areas, such as in his bed or on the floor in the bathroom, bedroom, dayroom, etc.
- 2. Agitation - Behaviors which typically precedes more disruptive behaviors, including: Significant dilation of his eyes, red nose, facial contortions, constant flipping of his glasses, odd physical movements, increased motor activity, threatening gestures, oppositional behaviors, and inappropriate vocalizations.
- 3. Aggression to people - Out of anger, any behavior which could result in significant injury to others, including: Hitting, kicking, punching, pinching, scratching, using an object as a weapon, etc.
- 4. Self-Injurious behaviors - Out of anger, any behavior which could result in bodily injury to himself, including: Facial hitting, pinching self, headbanging, hitting or kicking self, etc.

- B. **Risk/Implication of Targeted Behaviors:** ██████ has clearly demonstrated his ability to be highly disruptive and aggressive toward himself and others to the point where injury occurs unless the behavior is stopped. His maladaptive behaviors have also significantly hinders his ability to engage in a wide variety of community

activities and preclude him from residing in a more normalizing community environment.

The proposed program procedures are designed to provide [REDACTED] with an opportunity to learn more appropriate ways to deal with his frustration and anger and to live in a less restrictive setting. This treatment program includes establishing preventative procedures and conditions, training of replacement behaviors, and implementing nonrestrictive and restrictive intervention procedures to protect him and others from injury.

#### IV. TREATMENT PROCEDURES:

##### A. Preventive Program Components:

1. Environmental Adjustments - [REDACTED] generally prefers a relatively quiet and calm environment which enables him to occupy his time with leisure activities, such as drawing, writing, doing math problems, and look at magazines. On some occasions, when the noise and activity levels increase, particularly when other clients become disruptive, he may become distracted, annoyed, and agitated and begin to have behavioral difficulties. Therefore, Staff should attempt to maintain a relatively quiet and therapeutic environment while at the same time respond to his attentional and training needs.
2. Independence - Because [REDACTED] is a very capable individual who is able to initiate and complete the majority of his self-care and community living activities, he should have some control over as many of these activities as possible.

Staff must also not only enable [REDACTED] to maintain his current level of independence but develop and refine additional social and interpersonal skills to prepare him for the eventual move into a less restrictive environment, preferable into a community-based residential program. To this end, [REDACTED] should be offered a variety of community-based activities, e.g., recreational programs, shopping, restaurants, etc. (particularly since he enjoys



going into the community). [REDACTED] currently participates in Community Awareness, Special Olympics, and other off-Unit activities (e.g., is occasionally involved in activities with a peer group in Building 8).

3. Individualized Choices - [REDACTED] has clearly demonstrated his ability to make appropriate choices in a number of areas, including those in leisure and community living. Therefore, to the greatest extent possible, he should be directly involved in making choices whenever they are possible, such as his clothing as well as vocational, recreational, meals/snacks (if possible), and leisure activities for his daily activity schedule. Since food has historically been a source of difficulty for [REDACTED], he should continue to receive information and training regarding his dietary needs as well as the rationale for any food restrictions.

4. Attention - [REDACTED] need for attention continues to be regularly displayed. This is particularly evident in his effort to communicate with staff and will frequently become perseverative if he does not immediately receive a response from staff. Staff should talk with [REDACTED] whenever he wants to talk, regardless of the topic. At the same time, staff must respond to him in an appropriate manner, i.e., answer his questions but redirect and set limits when he begins to perseverate. Therefore, staff should periodically communicate or interact with [REDACTED] in such a manner that each event is clearly and appropriately initiated and terminated.

- B. Positive Program Components: Adaptive Behaviors will be reinforced within the context of [REDACTED] daily activity schedule. Staff attention and/or interaction will be used as the primary form of reinforcement but, in some situations, other more tangible reinforcers will be used (Note: all foods/drinks used as reinforcers must be approved by the Dietitian.) The use of response contingent procedures appear to be the most clinically appropriate procedure at this time.

1. Cooperation - [REDACTED] will continue to remain on a cooperation training program in which he will be requested to complete a variety of activities as part of his treatment and training program, including but not limited to the following: participation in group and individual leisure and recreational activities, completion of self-care tasks, and related community living activities. Cooperation will be defined as responding appropriately to staff requests within 3 verbal prompts.

A Differential Reinforcement of Incompatible behaviors (DRI) schedule will be used to reinforce all cooperative behaviors. Data will be collected every Wednesday by Unit staff, summarized monthly by the Psychology Assistant, and reviewed monthly in the CRS by the Psychologist.

2. Relaxation Training: [REDACTED] has been trained in this technique since his admission to NVTC. Currently, he responds relatively consistently to staff when prompted and continued training is not necessary at this time. Relaxation techniques will continue to be suggested whenever [REDACTED] becomes agitated and problem-solving procedures are ineffective. Staff will ask him to be seated on the mat or a chair and take some deep breaths. Staff may try to keep him calm by reminding [REDACTED] to stay relaxed and, if necessary, may ask him to count as he continues to take a specified number of deep breaths.

3. Prosocial Behaviors - A DRI reinforcement schedule will be used to verbally reinforce all appropriate behaviors. Behaviors to be reinforced will include, but not limited to the following: use of leisure time and material, socially interacting with all staff, performance of daily living skills, and participation in individual and group activities. Data will be collected every Wednesday by Unit staff, summarized monthly by the Psychology Assistant, and reviewed monthly in the CRS by the Psychologist.

C. **Interdisciplinary Training Programs:** [REDACTED] will be provided with formal training from other NVTC Departments as part of his total habilitation program. These programs will be designed to provide him with self-care and community living skills as well as alternative replacement behaviors to his maladaptive behaviors.

1. Communication - [REDACTED] is currently able and willing to participate in a conversation and can relate events sequentially. [REDACTED] will now focus on staying on topic and developing turn-taking skills. See Speech Therapist's program for details.
2. Therapeutic Recreation - The need for physical activity is addressed through recreation, i.e., given choices among 3 different circuit stations, stationary bike, and the trampoline. Community-based and off-Unit activities are also offered through Therapeutic Recreation. See Recreation Therapist's program for details.
3. Academic Skills (Communication) - [REDACTED] has 2 formal programs which provides him with regular training and individualized attention. One is to maintain his reading and arithmetic skills and the other is to use the computer for training in specified areas, skill acquisition, and leisure. See Speech Therapist's program for details.
4. Skills Training Center (STC) - This is a vocationally-based program in which work production is targeted. See STC program for details.

V. **BEHAVIORAL INTERVENTION PROCEDURES:**

The following reactive procedures will be implemented until [REDACTED] becomes calm. Calm will be defined as the absence of all targeted maladaptive behaviors for 5 minutes, not to exceed 60 minutes. All interventions are not to exceed 60 minutes without the approval of a Psychologist.

- A. **Maladaptive Behaviors: Reactive Procedures.** All targeted maladaptive behaviors will be addressed using (1) a graduated system of interaction ranging from verbal

and nonphysical methods to physical interactions as well as (2) the specific procedures designed to address each category of identified behaviors.

1. Inappropriate Urination - This behavior tends to occur between the time [REDACTED] goes to bed at night and waking up in the morning. Staff will verbally prompt him to use the bathroom when he gets up at any time during the night. However, if he inappropriately urinates, either in his bed or on the floor, he will be requested to reconstitute using verbal and gestural prompts. After the area is clean, he may return to bed.
2. Agitation - Staff should immediately intervene in a supportive manner and attempt to problem-solve and redirect [REDACTED] when he becomes agitated and begins to display precursors to aggression (see definition above).

A graduated system of interaction will be used beginning with (1) Nonphysical techniques, i.e., problem-solve, instructed relaxation, redirect, and limit-set. (2) If he remains agitated, he will be prompted to sit on a mat until calm. (3) If he remains agitated or refuses to comply the request to sit on the mat, he will be prompted to self restrain until calm.

If the above procedures are ineffective and [REDACTED] becomes a threat to himself or others, (4) staff will implement Crisis Management procedures as described in Section VI: PHYSICAL INTERACTION TECHNIQUES.

3. Aggression to people - If [REDACTED] is aggressive to staff or clients, (1) he will be prompted to sit on a mat and go through the relaxation sequence until calm. (2) If he remains agitated or refuses to comply the request to sit on the mat, he will be prompted to self restrain until calm.

If the above procedures are ineffective and [REDACTED] becomes a threat to himself or others, (4) staff will implement Crisis Management procedures as

described in Section VI: PHYSICAL INTERACTION TECHNIQUES.

4. Self-injury - Same as Aggression to people.

- B. **Crisis Management:** Crisis management procedures will be used at any time or place, as described in Section VI: PHYSICAL INTERACTION TECHNIQUES, if ██████'s behavior is determined to be a potential danger to himself or others. The Crisis Management Form must be completed as soon as possible if crisis management procedures are used.

#### VI. PHYSICAL INTERACTION TECHNIQUES: Restraints

In the event that personal and/or mechanical restraints are required to assist in the management of ██████'s behavior, as prescribed in either (1) his behavioral program or for (2) health and safety reasons, i.e., Crisis Management, these procedures will be based on the Mandt System and implemented according to DMHRSAS and NVTC policies. Since restraints are not a part of Ken's formal program, all restraints must be conducted and processed as a form of Crisis Management.

If a restraint is needed to manage ██████'s behavior, staff will first implement a personal restraint. If, according to the judgement of the shift supervisor or the in-charge person, ██████'s condition (i.e., his emotional state, severity of his aggression, etc.) can be better managed with mechanical restraints, then a Psychologist must be contacted for consultation and then approval. It is recommended that the Psychologist be notified within 10 minutes following the initiation of the personal restraint.

The interactive procedures as well as the guidelines described below were developed according to ██████'s current behavioral needs.

- A. **Personal Restraint:** The nature of the restraint should always be dictated by the individual, i.e., sufficiently flexible within specified limits to consider ██████'s psychological responses to restraints, the behavioral topography, his strength, size, etc. Therefore, whenever possible, the restraint should be conducted according to the following preferred sequence of alternatives.

1. Number of Staff - The minimum number of staff required to implement a personal restraint is two trained staff with sufficient physical interaction skills to deal with [REDACTED]'s size and strength. And, if additional staff are present, then their involvement will be directed by the restraint "team leader."
2. Restraint Position - The preferred restraint position is standing because it will make movement into a quiet area or his bedroom, if necessary, easier and safer. As indicated by David Mandt, "it may become necessary to restrain a person who has become aggressive or out-of-control on the ground. We feel it is best to try to restrain the person standing up first; however, you may not have any choice (The Mandt System, page 4-14)." This is applicable to [REDACTED].

The order of preferred restraint positions is as follows:

- (1) Standing 2-3 person restraint
  - (2) Sitting down (2-3 staff)
  - (3) Lying down (at least 3 staff and preferably with [REDACTED] lying on his side)
3. Body Mass - The most typical method of initiating a restraint is to bring the individual's body under control by securing "body mass." Therefore, the most experienced staff should be the person to make the first physical contact to at least manage his body. The second staff will then assist in managing the arm(s) and, if necessary because of the presence of other clients or activities, begin moving [REDACTED] into the Quiet Room. If [REDACTED] drops to the floor, the 2nd/3rd staff will be responsible for managing the legs.
  4. Management of Arms/Legs - As a general rule, physically manage only as much of [REDACTED]'s body as necessary to protect him and staff from harm. If [REDACTED] is restrained in a standing position, staff must be aware that he will attempt to bite, headbutt, and kick (however, his legs do not need to be held

if he is properly position away from other people). If the restraint is conducted in a sitting or lying position, then the legs must be held by at least one staff.

The order of preference in securing ██████'s arms, regardless of the restraint position, is as follows:

- (1) One-arm standing/seated/lying down
- (2) Two-arms standing/seated/lying down

**B. Mechanical Restraint:** If mechanical restraints are required, per Crisis Management policy, then the following adjustments will need to be made:

1. Number of Staff - A minimum of 3 staff should be involved. The first step involves the management of ██████ by placing him in a personal restraint.

The second step will involve a lift and carry procedure. One staff will place ██████ in a 2-arm restraint while the other 2 staff will securely hold each of his legs. Care must be taken since ██████ will attempt to headbutt and bite. ██████ will then be lifted and carried to his bed.

2. Restraint Position - ██████'s bed will be prepared as follows: (a) A pillow positioned at the headboard to prevent headbanging when ██████ is transferred to the bed. (b) Wrist and ankle restraints will be attached to the bed. (c) The chest restraint will be nearby for easy access when needed.

██████████ will be placed in a supine position (facing up) on his bed. The restraint will be maintained while the legs are secured with ankle cuffs by each staff. The staff will then take each of ██████'s arms while the restraining staff removes her/himself from ██████. Each arm will then be secured with wrist cuffs. The chest restraint will be added to prevent ██████ from bouncing on his bed.

Staff must be able to put two fingers between ██████ and the wrist and ankle restraints to ensure their

proper application. There must also be sufficient padding to prevent irritation of the arm pits when the chest restraint is applied and at least 1 inch of space between the chest restraint and ██████'s chest when the restraint is pulled away from his chest.

3. Monitoring by Staff - ██████ will be under constant visual monitoring while he is in restraints. Particular attention will be given to (a) ██████'s physical condition, i.e., breathing, temperature, perspiration, skin color, and any other atypical bodily changes. The restraints will also be physically checked at least every 15 minutes.

#### VII. SCHEDULE OF PROGRAM IMPLEMENTATION:

The behavioral program should be implemented at all times and all locations except in emergencies situation when adjustments may to be made for programmatic and/or for health and safety purposes. For example, in the event of an emergency, e.g. fire, all formal interaction procedures will be immediately terminated and ██████ will be escorted out of the building. If he remains disruptive and/or becomes aggressive, and is a threat to people, property, or himself, a physical restraint procedure as describe above will be implemented (Section VI - PHYSICAL INTERACTION TECHNIQUES). The Crisis Management Form must be completed if either a personal or mechanical restraint is used.



VIII. PSYCHOTROPIC MEDICATION:

[REDACTED] currently receives psychotropic medication in the form of Clozapine and Lithobid. Other medications which have been tried in the past to assist in the management of his behavior include: Tegretol, Buspar, Klonopin, Ativan, and Clomipramine.

Additional information can be found in the notes filed in the CRS and in Resident Records by the physician, pharmacist, and psychiatrist.

IX. RELEVANT LITERATURE:

The proposed treatment procedures are consistent with current professional practice.

X. ADVERSE REACTIONS:

No adverse side-effects are anticipated at this time as a result of implementing the current program other than what would normally be expected when an individual is upset and physical interaction procedures are required to manage the aggressive behaviors, i.e., physically guiding [REDACTED] onto the mat, assisting [REDACTED] assume the learned relaxation posture, and the application of a personal restraint. As with all physical intervention procedures, the probability of injury to staff or client (i.e., in the form of bruises, scratches, fractures, and biting) always exists. With proper training in all aspects of nonphysical and physical intervention procedures (i.e., Mandt System of Interaction) as well as the application of mechanical (e.g., if needed as part of a Crisis Management procedure), no significant injuries are expected to either [REDACTED] or staff.

**XI. DOCUMENTATION:**

- A. **Adaptive Behaviors:** All targeted adaptive and/or replacement behaviors displayed by [REDACTED] will be documented by staff according to the data collection schedule noted above.
- B. **Maladaptive Behaviors:** The following information will be recorded on the Behavior Program Record each time [REDACTED] displays a targeted maladaptive behavior: Date and time of the maladaptive behavior; type of behavior; frequency, duration, and intensity of the behavior; the behavioral intervention(s); and the antecedent(s) to the behavior.

**XII. PROGRAM EVALUATION:**

- A. Adaptive and maladaptive behavior data will be collected by Residential Services staff. The data will be summarized and reviewed regularly, i.e., weekly, monthly or as needed, by the Psychologist and/or the Psychology Assistant.
- B. Adaptive and maladaptive behavior data will be reviewed, evaluated, and reported in the client's CRS by the Psychologist on at least a monthly basis.
- C. Consultations with clinical and other NVTC staff involved in [REDACTED]'s treatment will be documented in the CRS. All outside consultants' reports will also be entered into the CRS along with their recommendations. If the IDT does not accept any or all of the recommendations, the IDT's rationale will also be entered into the CRS.
- D. There will be programmatic revisions or a total rewrite if data, direct observation, and/or input from direct care staff suggest the need. All revisions will require the approval of the Interdisciplinary Team.

XIII. MEDICATION INFORMATION:

These are the medications prescribed at the time this program was written. Changes in specific medication and/or dosage may occur during the course of this program. For the most current medication orders, refer to the Pharmacy report, Physician's notes, and Psychiatrist's orders.

receives psychotropic medication at this time. In the event that additional medication is needed to assist in the management of his behavior, the minimal therapeutic dose of psychotropic medication (i.e., medication prescribed specifically to help manage behavior) will be used in conjunction with this behavior program to help maintain the lowest possible rate of target behavior(s). There is a goal to gradually reduce and finally eliminate all psychotropic medication when possible; however, it can be expected that some individuals may function better with medication than without. Therefore, the type of medication prescribed and its dosage level will be modified (increased or decreased) as dictated by the client's behavior and side-effects of medication. Any potential harmful effects from the drug have been weighed against the potential behavioral benefits and the benefits clearly outweigh the side-effects of the drug. Reviews of medication and target behavior(s) will be conducted at least monthly, and more often if necessary to facilitate an optimal therapeutic response.

| Medication: | Dosage:   | Prescribed for:                 |
|-------------|-----------|---------------------------------|
| Clozapine   | 400 mgs.  | Behavior (aggression, Autistic) |
| Lithobid    | 1200 mgs. | Behavior (aggression, Autistic) |
| Insulin     |           | Diabetes (imp. diet)            |

Dr. J. J. [Signature]  
 Physician

2/1/95  
 Date

1/03/95

I am fully aware of the physical interaction techniques of the Mandt System that may be used to assist in the management of [REDACTED]'s behavior, either (1) as part of the approved plan of intervention specified in his behavioral program, or (2) in the form of a personal and/or mechanical restraint in the event that Crisis Management Procedures are required. There are no medical contraindications for their use at this time within the context of the preceding intervention plans.

David S. Gellman  
Physician

Date 20/05/2020

The Psychologist will in-service the Psychology Assistant(s) working directly with Ken and the staff on his Unit. The Psychologist and/or Psychology Assistant will then in-service all staff working directly with [REDACTED]. This in-service will include the following: (1) reading of the behavioral program with staff and providing staff with the rationale for the various treatment procedures; (2) being available to answer questions about the program; and (3) modeling the correct implementation of the program. The Psychologist and Psychology Assistant will provide on-going direct observation and give immediate feedback to staff concerning correct and/or incorrect implementation of the program procedures.

Tad Uno, Ph.D. 1/5/92  
Licensed Psychologist #648

Tad Uno, Ph.D. Date  
Supervising Psychologist



DATA SUMMARY SHEET MAI ADAPTIVE BEHAVIORS & CONSEQUENCES

Name: [REDACTED]

REG # 745

UNIT: SUU

Year: 1994

|     | Frequency Maladaptive Behaviors |    |    |    |    |    | Non-Physical |     | DR/DA/SH |     | Time Out |     | Physical |     | St on Mat |     | Self-Restraint |     | 2 points |     | C-SM |     | Crisis |     | Program |     | Chemical |     | TOT EPISODES |     |
|-----|---------------------------------|----|----|----|----|----|--------------|-----|----------|-----|----------|-----|----------|-----|-----------|-----|----------------|-----|----------|-----|------|-----|--------|-----|---------|-----|----------|-----|--------------|-----|
|     | A                               | B  | C  | D  | E  | F  | FHQ          | DUR | FHQ      | DUR | FHQ      | DUR | FHQ      | DUR | FHQ       | DUR | FHQ            | DUR | FHQ      | DUR | FHQ  | DUR | FHQ    | DUR | FHQ     | DUR | FHQ      | DUR | FHQ          | DUR |
| AM  |                                 |    |    |    |    |    |              |     |          |     |          |     |          |     |           |     |                |     |          |     |      |     |        |     |         |     |          |     |              |     |
| Jan | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Feb | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Mar | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Apr | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| May | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Jun | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Jul | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Aug | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Sep | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Oct | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Nov | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Dec | 12                              | 12 | 12 | 12 | 12 | 12 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| PM  |                                 |    |    |    |    |    |              |     |          |     |          |     |          |     |           |     |                |     |          |     |      |     |        |     |         |     |          |     |              |     |
| Jan | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Feb | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Mar | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Apr | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| May | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Jun | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Jul | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Aug | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Sep | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Oct | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Nov | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Dec | 11                              | 7  | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| NOC |                                 |    |    |    |    |    |              |     |          |     |          |     |          |     |           |     |                |     |          |     |      |     |        |     |         |     |          |     |              |     |
| Jan | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Feb | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Mar | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Apr | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| May | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Jun | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Jul | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Aug | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Sep | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Oct | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Nov | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |
| Dec | 10                              | 10 | 10 | 10 | 10 | 10 | 1            | 20  | 10       | 10  | 10       | 10  | 10       | 10  | 10        | 10  | 10             | 10  | 10       | 10  | 10   | 10  | 10     | 10  | 10      | 10  | 10       | 10  | 10           | 10  |

Program Charges:

BEHAVIORS  
A Agitation (1,2,3,5)  
B Aggression to People (2,3,4)  
C SB (2,3,4)

Other:

Name: [REDACTED] REG #: 745 UNIT: 500 Year: 1994

Use range sense for columns not used. Do not use the shading because it takes up too much disk space.

| Total<br>MTH | Frequency Measure Behavior |   |   |   |   |   | Non-Physical<br>Mand |     | OR/QA/BR<br>Residue |     | Time Out |     | Physical<br>Mand |     | St on Mat |     | Self-Restraint |     | 2 points |     | C-Size<br>Calm |     | Crisis<br>Management |     | Program<br>Extension |     | Chemical<br>Intervention |     | TOTAL EPISODES |     |
|--------------|----------------------------|---|---|---|---|---|----------------------|-----|---------------------|-----|----------|-----|------------------|-----|-----------|-----|----------------|-----|----------|-----|----------------|-----|----------------------|-----|----------------------|-----|--------------------------|-----|----------------|-----|
|              | A                          | B | C | D | E | F | FHQ                  | DUR | FHQ                 | DUR | FHQ      | DUR | FHQ              | DUR | FHQ       | DUR | FHQ            | DUR | FHQ      | DUR | FHQ            | DUR | FHQ                  | DUR | FHQ                  | DUR | FHQ                      | DUR | FHQ            | DUR |
|              |                            |   |   |   |   |   |                      |     |                     |     |          |     |                  |     |           |     |                |     |          |     |                |     |                      |     |                      |     |                          |     |                |     |
| Jan          | 10                         | 7 | 8 | 0 | 0 | 0 | 4                    | 51  | 0                   | 0   | 0        | 0   | 0                | 0   | 8         | 81  | 7              | 65  | 4        | 70  | 2              | 52  | 0                    | 0   | 0                    | 0   | 0                        | 0   | 15             | 347 |
| Feb          | 7                          | 1 | 3 | 0 | 0 | 0 | 4                    | 37  | 0                   | 0   | 0        | 0   | 0                | 0   | 2         | 18  | 1              | 12  | 3        | 35  | 2              | 33  | 0                    | 0   | 0                    | 0   | 0                        | 0   | 7              | 133 |
| Mar          | 2                          | 0 | 0 | 0 | 0 | 0 | 2                    | 6   | 0                   | 0   | 0        | 0   | 0                | 0   | 1         | 6   | 0              | 0   | 0        | 0   | 0              | 0   | 0                    | 0   | 0                    | 0   | 0                        | 2   | 12             |     |
| Apr          | 6                          | 4 | 7 | 0 | 0 | 0 | 6                    | 64  | 0                   | 0   | 0        | 0   | 0                | 0   | 6         | 66  | 1              | 15  | 3        | 85  | 1              | 15  | 0                    | 0   | 0                    | 0   | 0                        | 0   | 14             | 276 |
| May          | 8                          | 0 | 3 | 0 | 0 | 0 | 6                    | 42  | 0                   | 0   | 0        | 0   | 0                | 0   | 6         | 37  | 2              | 3   | 2        | 73  | 1              | 7   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 8              | 162 |
| Jun          | 7                          | 0 | 1 | 0 | 0 | 0 | 5                    | 54  | 0                   | 0   | 0        | 0   | 0                | 0   | 6         | 30  | 2              | 18  | 0        | 0   | 0              | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 8              | 108 |
| Jul          | 21                         | 5 | 4 | 0 | 0 | 0 | 13                   | 78  | 0                   | 0   | 0        | 0   | 0                | 0   | 18        | 180 | 7              | 90  | 4        | 84  | 0              | 0   | 0                    | 0   | 0                    | 0   | 0                        | 22  | 616            |     |
| Aug          | 10                         | 1 | 3 | 0 | 0 | 0 | 6                    | 44  | 0                   | 0   | 0        | 0   | 0                | 0   | 6         | 35  | 2              | 14  | 0        | 0   | 0              | 0   | 0                    | 0   | 0                    | 0   | 0                        | 10  | 80             |     |
| Sep          | 6                          | 1 | 3 | 0 | 0 | 0 | 2                    | 30  | 0                   | 0   | 0        | 0   | 0                | 0   | 2         | 10  | 1              | 8   | 0        | 0   | 1              | 6   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 6              | 64  |
| Oct          | 10                         | 2 | 3 | 0 | 0 | 0 | 2                    | 2   | 2                   | 20  | 0        | 0   | 0                | 0   | 6         | 27  | 1              | 45  | 2        | 42  | 0              | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 10             | 142 |
| Nov          | 2                          | 0 | 1 | 0 | 0 | 0 | 2                    | 20  | 0                   | 0   | 0        | 0   | 0                | 0   | 1         | 1   | 1              | 12  | 0        | 0   | 0              | 0   | 0                    | 0   | 0                    | 0   | 0                        | 2   | 37             |     |
| Dec          | 10                         | 1 | 0 | 0 | 0 | 0 | 6                    | 43  | 1                   | 12  | 0        | 0   | 0                | 0   | 0         | 112 | 6              | 60  | 1        | 18  | 0              | 0   | 0                    | 0   | 0                    | 0   | 0                        | 0   | 9              | 260 |

| SIC |   |   |   |   |   |   |   |    |   |   |   |   |   |   |    |    |    |    |    |    |   |   |   |   |   |   |   |   |    |    |
|-----|---|---|---|---|---|---|---|----|---|---|---|---|---|---|----|----|----|----|----|----|---|---|---|---|---|---|---|---|----|----|
| Jan | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  |
| Feb | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  |
| Mar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  |
| Apr | 1 | 0 | 1 | 0 | 0 | 0 | 2 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1  | 1  |
| May | 3 | 1 | 0 | 0 | 0 | 0 | 3 | 71 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 1  | 2  | 1  | 32 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 10 | 10 |
| Jun | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  |
| Jul | 7 | 3 | 4 | 0 | 0 | 0 | 6 | 23 | 0 | 0 | 0 | 0 | 0 | 0 | 3  | 35 | 4  | 40 | 1  | 45 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 15 | 15 |
| Aug | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  |
| Sep | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0 | 0 | 0 | 0 | 0 | 1 | 20 | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2  | 2  |
| Oct | 2 | 0 | 1 | 0 | 0 | 0 | 2 | 30 | 0 | 0 | 0 | 0 | 0 | 1 | 10 | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4  | 4  |
| Nov | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 11 | 0 | 0 | 0 | 0 | 0 | 1 | 5  | 0  | 0  | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1  | 1  |
| Dec | 3 | 0 | 2 | 0 | 0 | 0 | 3 | 32 | 0 | 0 | 0 | 0 | 0 | 1 | 18 | 1  | 25 | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 7  | 7  |

Program Changes:

BEHAVIORS: A Agitation (1,2,3,5)  
B Agitation People (2,3,4)  
C SM (2,3,4)

# DATA SUMMARY SHEET: ADAPTIVE BEHAVIORS

CLIENT:                       
REG #: 745

UNIT: 5

YEAR: 1994

| MONTH     | ADAPTIVE<br>BEHAVIORS<br>PER PROBE | COMPLIANCE<br>CUMULATIVE PERCENT |      |       |        | # TRIALS | OTHER |  |
|-----------|------------------------------------|----------------------------------|------|-------|--------|----------|-------|--|
|           |                                    | 1 VP                             | 2 VP | 3 VP  |        |          |       |  |
| JANUARY   | 14.25                              | 1.67                             | 83   | 98    | 100    | 239      |       |  |
| FEBRUARY  | 32.75                              | 7.44                             | 93   | 100   |        | 215      |       |  |
| MARCH     | 36.8                               | 14.4                             | 94   | 99    | 100    | 236      |       |  |
| APRIL     | 36.75                              | 16.7                             | 94   | 97    | 99.57  | 233      |       |  |
| MAY       | 34.75                              | 0.82                             | 85   | 98    | 99     | 244      |       |  |
| JUNE      | 32.75                              | 2.04                             | 86   | 98    | 100    | 198      |       |  |
| JULY      | 34.3                               | 5.8                              | 90   | 92    | 97     | 223      |       |  |
| AUGUST    | 33.8                               | 0.82                             | 83   | 95    | 100    | 243      |       |  |
| SEPTEMBER | 28                                 | 1.29                             | 86   | 99.57 | NO 3's | 232      |       |  |
| OCTOBER   | 28.67                              | 0                                | 87   | 97    | 99     | 231      |       |  |
| NOVEMBER  | 25.2                               | 3.1                              | 73   | 94    | 99.58  | 228      |       |  |
| DECEMBER  | 28.75                              | 7                                | 90   | 97.5  | 99.59  | 242      |       |  |

TARGETED ADAPTIVE BEHAVIORS:

TYPES OF REINFORCERS:

PROGRAM CHANGES:



NORTHERN VIRGINIA TRAINING CENTER  
FOR THE MENTALLY RETARDED

Medical Plan for Psychotropic Drug Use

Name: [REDACTED] Unit: 6 DOB: 10/15/43 REG NO: 000745

**History of Psychotropic Drug use and Previous Behavioral Procedures Tried:**

[REDACTED] has been on a variety of psychotropic medication over the years. Most recently, he has been treated with a combination of Lithium and Tegretol. In the past, when he was a teenager, there were several trials of neuroleptic medication that allegedly led to a severe tardive dyskinesia. For these reasons, since he was a teenager, neuroleptic medication has never been prescribed again. Unfortunately, [REDACTED] often appears quite psychotic and the manifestations of his psychosis are not helped much by the prescription of Lithium and Tegretol.

**Name of Psychotropic Drug, Frequency, Dosage, Route of Administration and Plans to Achieve Therapeutic Level:**

The medication to be tried is Clozapine up to a dosage of 900 mg daily. This medication has been tried in Europe for the past 20 years and found not to cause extrapyramidal symptoms or tardive dyskinesia.

**Target Maladaptive Behavior to be modified:**

Other: Self-abuse, physical aggression, disruptive behavior

Monthly Frequencies: See Psychologist's notes.

| Month | Total | Month | Total |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Name of Psychiatric Consultant: Dr. Edward I. Pressman

**List of Potential Side Effects of the Psychotropic Drug:**

a) Major Side Effects:

Agranulocytosis, hypotension, seizures

b) Minor Side Effects:

Constipation, dizziness, fever, hypertension, sedation, salivation, tachycardia, and weight gain

**Medical Review of Side Effects (by whom, frequency, outcome of review) including Laboratory Work if Indicated:**

Secondary to the possibility of agranulocytosis, anyone who takes Clozaril must be monitored, under the Clozaril monitoring system. This includes a weekly white count and differential, which is reviewed by the prescribing physician and pharmacist before the medication then can be prescribed. In addition, other side-effects will be monitored by unit staff, unit nurses, the unit physician, and consulting psychiatrist.

Medical Plan for Psychotropic Drug Use

Plans to be Implemented in the Event of Side Effects:

In the event of signs or symptoms of agranulocytosis, the Clozaril will be immediately discontinued and [redacted]'s white count will be monitored daily. Other side-effects are dealt with by dosage reduction or change in timing of dosage prescription.

Statement Regarding Resident's Harmful and Undesirable Behavior Overweighing the Drug's Potential Harmful Side Effects:

It is the opinion of this psychiatrist that the [redacted]'s undesirable behavior outweighs the potential harmful side effects of Clozaril.

Concurrent behavior Programs (if any) Designed by the Interdisciplinary Team for the Target behavior: Psychologist's section

See activity schedules for the reinforcing environments.

See behavioral plans of the target behaviors \_\_\_\_\_

(See section 5)

Medical Plans, including Objective for Review based on Available Collected Behavior Charts including Review Frequency, how documented and if possible, Plan for Readjusting, Reducing or Discontinuing the Drug:

Psychotropic medication reviews will continue, as they always have, on a weekly basis. Specific data will be collected and presented at the weekly reviews and then decisions made about the dosage of medication. In the event of lack of response, the medication will be gradually decreased and discontinued.

Signed: \_\_\_\_\_

Howard I. Pressman, M.D.  
Consulting Psychiatrist

Date: 11/15/93

CONSENTS:

By Resident:

a) Competent adult-consent signed ( ). Unable to make medical decisions (✓).

By Parent/Guardian:

- a) Psychiatry conference attended and verbal consent given ( ).
- b) Consent given by telephone (✓).
- c) Consent given in writing (✓).

APPROVAL:

By Interdisciplinary Team: \_\_\_\_\_

Date: 10-15-93

By Psychologist: \_\_\_\_\_

Date: 11/15/93

EMC Approval: \_\_\_\_\_

Date: 10/15/93

LHRC Approval: \_\_\_\_\_

Date: \_\_\_\_\_

Submitting Attending Physician: \_\_\_\_\_

Date: 11/15/93

Oct. 18, 1993

Over Telephone, Approved by

LHRC: Mrs. Claire Jacques,  
Mrs. Ann Sale  
Mr. James Tiernan

\_\_\_\_\_ 11/15/93

NORTHERN VIRGINIA TRAINING CENTER

PERMISSION FOR ADMINISTRATION OF MEDICATION

I hereby give consent to Northern Virginia Training Center medical staff to administer to:

the medication:

Clozapine

The following adverse conditions which may occur as a result of the prescribed medication are listed below and have been explained to you by:

a) Major Side Effects:

Agranulocytosis, hypotension, seizures

b) Minor Side Effects:

Constipation, dizziness, fever, hypertension, sedation, salivation, tachycardia, and weight gain

I have been fully informed of the nature of the above medication, potential side effects and the reason for the use of the medication. I understand I can withdraw my consent at any time.

Signed: *David M. Lauer*

Relationship: *Att. Medical*

*Coachman*

Date: *10-18-93*

Witness: *John J. Murre*

Date: *10-18-93*

INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO \_\_\_\_\_)

| Date    | Target Behaviors Status                     | Prescribed Medications Dosage/Signature                                 | Physician's Comments                                            | Adverse Reactions                   |
|---------|---------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------|
| 8/10/94 | Severe agitation 2/0<br>Agg. 1/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Plan to visit next.                                             |                                     |
| 8/17/94 | Severe agitation 1/0<br>Agg. 0/0<br>SIB 1/0 | LiCO <sub>3</sub> 200-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Pretty good week.                                               |                                     |
| 8/24/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Stable                                                          |                                     |
| 8/31/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Good week.                                                      |                                     |
| 9/7/94  | Severe agitation 1/0<br>Agg. 0/0<br>SIB 1/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Stable                                                          |                                     |
| 9/14/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Stable, very involved in activities, handling frustration well. | Speech is slow when he is agitated. |
| 9/21/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Stable                                                          |                                     |
| 9/28/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 2/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. P. [Signature] | Down well                                                       |                                     |

Department of Mental Health, Mental  
Retardation, and Substance Abuse Services  
Northern Virginia Training Center  
INTERDISCIPLINARY NOTES  
All entries must be signed with name, title,  
and discipline. Use black ink.

ADDRESSOGRAPH  
#745  
NYTC 6MB  
UNAM 008 6-18-95  
FAX 1-7-86  
227-74-5683

INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO. \_\_\_\_\_)

| Date     | Target Behaviors Status                           | Prescribed Medications Dosage/Signature                                | Physician's Comments                                                                   | Adverse Reactions |
|----------|---------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------|
| 10/15/94 | Severe agitation 5/0<br>Aggression 1/0<br>SIB 1/0 | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Constant preoccupation, flammable contact (flamming), can be restricted easily though. |                   |
| 10/16/94 | Severe agitation 2/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Did well at camp. Such after camp - when he had the episode.                           |                   |
| 10/19/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/20/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/21/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/22/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/23/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/24/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/25/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/26/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/27/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/28/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/29/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/30/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |
| 10/31/94 | Severe agitation 0/0<br>Agg. 0/0<br>SIB 1/0       | LiCO <sub>3</sub> 300-300-600<br>Clopazine 150-250<br>H. Passman, M.D. | Continued over 700-1000.                                                               |                   |

Department of Mental Health Services  
Recreation and Substance Abuse Services  
Northern Virginia Training Center  
11111 Leesville Road, Suite 100  
Falls Church, VA 22041  
INTERDISCIPLINARY NOTES

All entries must be signed with name, title, and discipline. Use black ink.

ADDRESSOGRAPH

INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO \_\_\_\_\_)

| Date               | Target Behaviors Status                 | Prescribed Medications Dosage/Signature                                 | Physician's Comments                                                                           | Adverse Reactions |
|--------------------|-----------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------|
| 1/1/94<br>12/16/94 | Summary date 1/2<br>Agg. 0/0<br>SIB 0/2 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | Difficult sleeping at night - will awaken about morning for another crisis. Sleeps some sleep. |                   |
| 12/26/94           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | Mood episodes are food related and related to expectations.                                    |                   |
| 1/2/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | Some 7 age behavior events very weak. Concern about inappropriate attention at times.          |                   |
| 1/15/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 1/22/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 1/29/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 2/5/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 2/12/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 2/19/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 2/26/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 3/5/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 3/12/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 3/19/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 3/26/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 4/2/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 4/9/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 4/16/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 4/23/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 4/30/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 5/7/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 5/14/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 5/21/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 5/28/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 6/4/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 6/11/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 6/18/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 6/25/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 7/2/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 7/9/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 7/16/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 7/23/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 7/30/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 8/6/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 8/13/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 8/20/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 8/27/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 9/3/95             | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 9/10/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 9/17/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 9/24/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 10/1/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 10/8/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 10/15/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 10/22/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 10/29/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 11/5/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 11/12/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 11/19/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 11/26/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 12/3/95            | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 12/10/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 12/17/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 12/24/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |
| 12/31/95           | Summary date 1/2<br>Agg. 0/0<br>SIB 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clonazepam 150-250<br>H. Pausman, M.D. | No change in symptoms since last visit.                                                        |                   |

Department of Mental Health, Mental Health  
Intervention and Substance Abuse Services  
New South Wales, Australia

INTERDISCIPLINARY NOTES

ALL entries must be signed with name, title,  
and discipline. Use black ink.

ADDRESS ONLY 7-12

INTERDISCIPLINARY NOTES - (PSYCHOTROPIC MEDICATION PROBLEM NO \_\_\_\_\_)

| Date    | Target Behaviors Status                     | Prescribed Medications Dosage/Signature                                | Physician's Comments                  | Adverse Reactions |
|---------|---------------------------------------------|------------------------------------------------------------------------|---------------------------------------|-------------------|
| 2/15/95 | Severe agitation 3/0<br>Agg. 0/0<br>Sib 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Parnassian 10 | Basally stable.                       |                   |
| 2/15/95 | Severe agitation 3/0<br>Agg. 0/0<br>Sib 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Parnassian 10 | Continued stable. Had a good weekend. |                   |
| 2/15/95 | Severe agitation 3/0<br>Agg. 0/0<br>Sib 0/0 | LiCO <sub>3</sub> 300-300-600<br>Clozapine 150-250<br>H. Parnassian 10 | Continued stable withing.             |                   |
|         |                                             |                                                                        |                                       |                   |
|         |                                             |                                                                        |                                       |                   |
|         |                                             |                                                                        |                                       |                   |
|         |                                             |                                                                        |                                       |                   |
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|         |                                             |                                                                        |                                       |                   |
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Northern Virginia Training Center

INTERDISCIPLINARY NOTES

All entries must be signed with name, title,  
and discipline. Use black ink.

ADDRESSOGRAPH

## **Pre-Service Training for Direct Care Staff**

ATTACHMENT

8

**Policy:** All new employees classified as direct care staff must attend the orientation program and pre-service training classes required before beginning work on their assigned unit.

**Purpose:** The purpose of the pre-service training program is to prepare new employees to perform their assigned duties competently.

**Responsibility:** The Training Department is responsible for the administration, scheduling and coordination of the facility's pre-service training program.

**Exception:** An Assistant Director or Department Chief may submit a request for temporary deferral of pre-service training to the Training Director. Employees who obtain approval for temporary deferral must be scheduled for pre-service classes within the probationary period.

**Exemption:** If a supervisor wishes to exempt an employee from any part of the pre-service program, a request may be submitted in writing to the appropriate Senior Staff member. If approved, this will be forwarded to the Training Department for information and documentation in their Pre-Service Training Record.

**Direct Care Staff Defined:** Direct Care Staff include those staff whose job responsibilities necessitate interactions with the client.

**Direct Care Staff shall typically include employees classified as:**

- ◆ Developmental Aides
- ◆ Developmental Technicians
- ◆ Medication Aides
- ◆ Team Leaders
- ◆ Program Managers
- ◆ Recreation Therapists and Aides
- ◆ Special Activity Supervisors and Aides
- ◆ Other staff having direct contact with clients

**Required Pre-service Training for Direct Care Staff:** All direct contact staff will be required to attend Orientation and Pre-service training classes during the first month of employment.

**The employee will receive orientation and training in the following areas:**

- ◆ Personnel Policies and Procedures
- ◆ Resident Abuse Policy
- ◆ Resident Rights
- ◆ Safety and Security
- ◆ Mission Statement and Philosophy of NVTC
- ◆ Sexual Harassment
- ◆ Introduction to Mental Retardation
- ◆ Signs and Symptoms of Illness
- ◆ Vital Signs
- ◆ First Aid



- ◆ Nursing Arts/Personal Hygiene
- ◆ First Aid
- ◆ Body Mechanics/Lifting
- ◆ Nutrition and the Mentally Retarded
- ◆ Mealtime Techniques
- ◆ Mandt System of Managing People
- ◆ Normalization
- ◆ Behavior Modification
- ◆ ID Team Process
- ◆ Volunteer Services
- ◆ Sensitivity to People with Developmental Disabilities
- ◆ Teaching Techniques (Task Analysis, Prompting, Reinforcement, Error Correction)
- ◆ Data Collection
- ◆ Behavioral Documentation
- ◆ Client Record System
- ◆ Sexuality and the Mentally Retarded
- ◆ Communication and the Mentally Retarded
- ◆ Sign Language
- ◆ Dental Health
- ◆ Therapeutic Recreation Services
- ◆ Mechanical Restraint Procedures
- ◆ Side Effects of Medication
- ◆ Missing Client Policy
- ◆ Seizure Recognition and Observation
- ◆ Infection Control
- ◆ Crisis Management
- ◆ Direct Care Competency Training Program
- ◆ Cook-Chill Techniques
- ◆ Adult CPR
- ◆ Working with Families
- ◆ Active Treatment

**On the Job Training:** As soon as a new staff has been assigned to a unit, and before the end of the employee's probationary period, approximately six (6) months, all new direct contact staff will complete the Direct Care Competency Training Program.  
(See separate section for description)

**Class Schedules:** Training schedules shall be prepared by the Training Department and disseminated to employees, supervisors, and instructors.

**Attendance Required of Re-hired Employees:** Employees re-hired twelve (12) months or more after separation from the facility are required to attend orientation and pre-service training classes upon their return. Employees re-hired six (6) months or less after leaving the facility are required to attend the Abuse and Human Rights classes only.

If there have been no significant changes in the training program since the employee last attended a particular class, attendance at those particular sessions may be waived, pending approval of the employee's Department Chief or Program manager and the Director of Training.

**Transfers Within the Facility:** Employees transferring within the facility from a support classification into a direct contact position must complete all required pre-service classes for direct contact staff during the month following the date of transfer.

**Expectation for Employees:** Employees in training programs are expected to:

- Attend all classes for which they are scheduled
- Be on time for each class
- Return from breaks and lunch periods at appropriate time
- Participate appropriately in the class activities
- Achieve established training competencies with established time frame

**Recording Attendance:** A pre-printed class roster will be available in the Training Room. Each instructor will circulate this roster for those in attendance to initial beside their name or sign if their name is not on the roster. Upon completion of each session, the instructor will send this roster to the Training Department, where the attendance will be noted on each individual's Pre-Service Training Record.

**Evaluation of Performance:** Each Support and Clinical Staff member is expected to perform at his/her optimal level and is required to attend all mandatory Pre-Service Training Classes.

Performance in each class will be evaluated in the following manner:

1. Numerical score of 75% or better (unless otherwise determined); or
2. Participation/attendance in required classes

Any Direct Care Staff member whose score falls below the designated mark or who fails to attend a required class will be notified in writing to attend the necessary classes the following month. A copy of the written notification will be sent to the individual's supervisor also.

**Incomplete Training Notifications:** If an employee needs to attend a pre-service class due to absence or failure to successfully complete it, the Training Department will send a written notice to the employee and their supervisor informing them of the schedule to return to training.

**Completion of Required Training:** Successful completion of the pre-service training requirement shall be documented on a Pre-Service Training Record by the Training Department. A copy of this form shall be sent to the Personnel Department for filing in the employee's personnel record. Employees failing to successfully complete the training program will be terminated from the agency or transferred to a position with different training requirements.

**Participant Evaluation:** Employees shall be given the opportunity to anonymously evaluate each pre-service training class they attend.

Evaluations are reviewed by the instructors and supervisory personnel staff in the Training Department. Feedback will be considered in making changes in the Pre-Service Training Program.

## TRAINING OUTLINE FORMAT

1. Title of Session: Policy on Abuse
2. Trainer(s): David H. Lawson  
Back-up Trainer(s): Lee Hilton and Video
3. Time Required: 1 hour and 30 minutes
4. Materials or Equipment Required: NVTC Policy on Abuse
5. Site of Session: Building 4/Training Room
6. Learning Objectives for Participants in Training Session:
  1. To explain nature of policy and rationale for State/NVTC
  2. To discuss ways to prevent situations which commonly lead to abuse.
7. Instructor Guide or Outline of Training Session (be very specific so that back-up trainer could teach from it effectively). Attach any handouts used in session
  - A. Statement of policy
    1. historical perspective
    2. rationale for its stringency
  - B. Definition and prevention
    1. physical
    2. verbal
    3. neglect
  - C. Responsibility of reporting
    1. to Director
    2. penalties
  - D. Investigation
    1. preliminary investigation
    2. full panel
    3. director's findings
    4. appeal to circuit court

TESTING - PENCIL AND PAPER TEST

EM: Proman\plcyabus

Subject Area: Human Rights

Purpose: Orient new employees to Human Rights Program

Audience: All new employees

Learning Goals:

- Discuss rights both for NVTC and DMHMRSAS Regulations
- Role of the advocate understood
- Complaint review process understood

Teaching Method(s): Lecture

Time Required: 1 hour 30 minutes

Materials Used:

- (Handouts)
- Outline
- Staff Responsibilities
- Resident Rights

Physical Setting: Classroom

Evaluation: Pencil and Paper Test/70% to pass

HUMANRTS

**SUBJECT AREA:** Safety and Security

**PURPOSE:** To acquaint new employees of safety and security programs.

**AUDIENCE:** All Employees

**LEARNING GOALS:**

- Instruct on rules and regulations
- Instruct on use of fire extinguisher
- Instruct on operation of state-owned vehicle

**TEACHING METHODS:**

Lecture

Demonstration: Use of fire extinguisher

**TIME REQUIRED:** One (1) hour and 30 minutes

**MATERIALS USED:**

Handouts  
Videotapes  
Fire Extinguisher

**EVALUATION:** Return demonstration: Use of fire extinguisher

**SUBJECT AREA:** Sexual Harassment

**PURPOSE:** Acquaint staff with Sexual Harassment Policy

**AUDIENCE:** All employees

**LEARNING GOAL(S):** -definition of sexual harassment by Dept. of  
Personnel and Training  
-penalties for engaging in sexual harassment  
-reporting allegations of sexual harassment  
-management responsibilities

**TEACHING METHOD(S):** Lecture  
Scenarios to emphasize definition

**TIME REQUIRED:** 30 minutes

**MATERIALS USED:** Handouts

**EVALUATION:** Class Participation

**SUBJECT:** Introduction to Mental Retardation and Developmental Disabilities

**PURPOSE:** - To acquaint staff with the American Association on Mental Retardation's definition of mental retardation.

**AUDIENCE:** All Staff

**LEARNING GOAL(S):**

- Look at the definition phrase-by-phrase.
- Define the 10 adaptive skill areas.
- Define levels of support.
- Causes of mental retardation.

**TEACHING METHOD(S):** Lecture

**MATERIAL(S) USED:** Handout: The Definition and its application.

**TIME REQUIRED:** 45 minutes

**PHYSICAL SETTING:** Classroom

**EVALUATION:** Paper, Pencil, Test; 70%

**Subject Area:** Normalization

**Purpose:** To discuss issue of normalization as foundation for planning and providing services to developmentally disabled people.

**Audience:** All Employees

**Learning Goal(s):** Heighten sensitivity to needs of institutionalized, disabled persons for dignity and respect.

**Teaching Method(s):**

**Time Required:** 1 hour

**Materials Used:** Handouts, Videotape

**Physical Setting:** Classroom

**Evaluation:** Class Participation

a:Normal



**Subject Area:**

Seizures

**Purpose:**

To familiarize staff with seizure recognition, observation and reporting.

**Audience:**

All Employees

**Learning Goal(s):**

To observe, accurately record and report the seizure behavior to medical staff, to provide appropriate first aid to person experiencing seizure, to provide appropriate and accurate information to other involved individuals, to describe only what you see, not diagnose.

**Teaching Method(s):**

Lecture

**Time Required:**

2 hours

**Materials Used:**

Handouts, videotape

**Physical Setting:**

Classroom

**Evaluation:**

Level 1 staff: Class participation  
Level 2 staff: Class participation  
Paper/pencil test: 90%

a:Seizures

SUBJECT AREA:

Infection Control

PURPOSE:

To establish measures which will prevent or limit the spread of infections and communicable diseases.

To minimize the risk of exposure to blood and body fluids, and prevent transmission of disease that is transmitted through blood or body fluids, i.e., AIDS and Hepatitis B.

AUDIENCE:

All employees at NVTC

LEARNING GOAL(S):

To prevent the spread of infections and disease to other clients, personnel and visitors. Handwashing is the single most important means of preventing the spread of infections.

TEACHING METHOD(S):

Lecture  
Demonstration of how to wear and remove disposable gloves  
Universal Precautions Video

TIME REQUIRED:

One (1) hour

MATERIALS USED:

Handouts

EVALUATION:

Class Participation

**SUBJECT AREA:** Body Mechanics and Proper Lifting Techniques

**PURPOSE:** To go over lifting and transfer techniques in an effort to reduce absenteeism due to job-related injuries resulting from body mechanics.

**AUDIENCE:** All new employees

**LEARNING GOALS:**

- Basic anatomy and posture
- Proper body mechanics
- Use of back support
- Lifting guidelines

**TEACHING METHOD(S):** Lecture, demonstration

**MATERIALS USED:** 2 Videotape<sup>(s)</sup>, Saf-t-Lift belt, box to lift

**EVALUATION:** Return demonstration: lifting box

**BODYLIFT**

SUBJECT AREA: First Aid

PURPOSE: To teach new staff basic aid, what to do until medical help arrives.

AUDIENCE: All Employees

LEARNING GOAL(S): To provide information to assist in identification of emergency situations and care to provide at that time.

TEACHING METHOD(S): Lecture  
Demonstration: Heimlich Maneuver  
Rescue Breathing

TIME REQUIRED: 2 hours and 45 minutes

MATERIALS USED: Handouts, Manikins

EVALUATION: Return Demonstration: Heimlich Maneuver  
Rescue Breathing  
  
Written test: 90%

SUBJECT AREA: Common Symptoms of Illness

PURPOSE: To detect clients' symptoms of illness

AUDIENCE: Direct Contact Staff

LEARNING GOAL(S): To provide information to assist in the identification of illness

To provide information on the cause and care of symptoms of illness

TEACHING METHOD: Lecture

TIME REQUIRED: 1 Hour, 30 Minutes

MATERIALS USED: Hand-out

PHYSICAL SETTING: Classroom

EVALUATION: Paper pencil test, 75%

#### SYMPTOMS

SUBJECT AREA:

Vital Signs

PURPOSE:

The taking of temperature, pulse and respiration is one of the first means used to try to learn about a client's condition.

AUDIENCE:

Direct Contact Staff

LEARNING GOAL(S)

- Instruct staff on how to recognize the vital signs of the clients.
- Instruct staff on the detection of changes in vital signs.

TEACHING METHOD(S)

Lecture  
Demonstration of how to take temperature  
Pulse  
Respiration

TIME REQUIRED:

One (1) hour

MATERIALS USED:

Handouts  
Thermometers - Mercury and Digital

EVALUATION:

Return demonstration of TPR

## TRAINING OUTLINE FORMAT

1. Title of Session: Dental Health Education
2. Trainer(s): Dental Staff      Dental Hygienist  
Back-up Trainer(s): Videotape
3. Time Required: 1 hour and 30 minutes
4. Materials or Equipment Required: Slide projector; other materials provided through clinic.
5. Site of Session: Building 4/Training Room
6. Learning Objectives for Participants in Training Session:
  - Philosophy of dental care
  - Staff responsibility re: client oral hygiene
  - Demonstration of proper teethbrushing technique
7. Instructor Guide or Outline of Training Session (be very specific so that back-up trainer could teach from it effectively). Attach any handouts used in session.

SEE ATTACHED

## SIDE EFFECTS OF MEDICATIONS

Purpose: To acquaint new residential service staff with side effects of medication.

Objectives: To have all new residential staff be aware that medications have side effects.

Materials: Video: Cognitive and Other Side Effects of Medications  
Handout

1. Information given includes, but is not limited to, a discussion of common side effects (e.g., nausea, vomiting, GI distress, rash, and elevated temperature)
2. Anticonvulsant medication discussion addresses sedation, dizziness, vision problems, and confusion.
3. Psychotropic medication discussion includes sensitivity to the sun and heat, as well as dry mouth, weight gain, etc.



# SENSITIVITY to PEOPLE with DEVELOPMENTAL DISABILITIES

## I. Introduction to Sensory Integration

### A. Definition

1. ability to take in, sort out, and connect information
2. in normal development sensory integration is usually automatic

### B. Description of Senses and How We Use Them

1. tactile (touch)
2. vestibular (balance)
3. olfactory (smell)
4. vision (sight)
5. auditory (hearing)

### C. Concept of Postural Security

### D. Concept of Motor Planning

### E. Summary of Sensory Integration

## II. Experiential Exercises

TIME REQUIRED: 1 hour and 30 minutes

SUBJECT AREA: Introduction to Sign Language

PURPOSE: To introduce to staff a system of communication that uses symbols to express thoughts or share information.

AUDIENCE: Direct Contact Staff

LEARNING GOAL(S):

- Understand what sign language is.
- Understand how signing is used with developmentally disabled people.
- Introduction of most commonly-used signs at NVTC.

TEACHING METHOD(S): Lecture and demonstration of signs.

TIME REQUIRED: One (1) hour

MATERIALS USED: Handouts, Sign Language Book

EVALUATION: Return demonstration of signs

SUBJECT AREA:

Services for the Hearing Impaired

PURPOSE:

To familiarize staff with the services provided to our hearing impaired clients.

AUDIENCE:

Direct Contact Staff

LEARNING GOAL(s):

- Prerequisites of normal and abnormal language development
- Indicators of hearing problems
- Hearing problems with people who are developmentally disabled
- Habilitation/intervention surgical/medical and hearing aids
- Hands-on experience with hearing aids and management tips
- Responsibilities of staff regarding hearing aid

TEACHING METHODS:

Lecture  
Demonstration of how to put on hearing aid

TIME REQUIRED:

One (1) Hour

MATERIALS USED:

Handouts, hearing aids, ear putty, ear plugs

EVALUATION:

Class Participation

SUBJECT AREA: About the Art of Communicating with  
Mentally Retarded People

PURPOSE:

- Understand what communication is
- Understand the problems of communicating with people who are mentally retarded.

AUDIENCE: Direct Contact Staff

LEARNING GOAL(S):

- Understand Speech and Language Development
- Understand problems in language growth
- Understand alternatives in verbal communication
- Understand helpful hints for successful communication

TEACHING METHOD(S):

TIME REQUIRED: One (1) hour

MATERIALS USED: Hand-outs  
Videotape  
Communication devices

EVALUATION: Class Partiicpation

SUBJECT AREA:

Nutrition

PURPOSE:

Familiarize staff with nutritional needs of client population.

AUDIENCE:

Direct Care Staff

LEARNING GOAL(S):

- Provide information on the role of the dietitian of NVTC.
- Provide information on different therapeutic and textured diets available at NVTC.
- Provide information about the nourishment and food reinforcement procedures at NVTC.

TEACHING METHODS:

Lecture

TIME REQUIRED:

Minutes

MATERIALS USED:

Handouts

EVALUATION:

Class Participation

**SUBJECT: COOK CHILL PROCEDURES**

**PURPOSE: TO ACQUAINT STAFF WITH COOKING PROCEDURES/  
EQUIPMENT**

**AUDIENCE: DIRECT CONTACT STAFF**

**TEACHING  
METHODS: LECTURE/RETURN DEMONSTRATION**

**TIME  
REQUIRED: 1 HOUR**

**MATERIALS: COOK CHILL EQUIPMENT  
FOOD TO COOK**

**EVALUATION: RETURN DEMONSTRATION**

**Subject Area:** Mealtime

**Purpose:** To provide information to staff regarding mealtime.

**Audience:** Direct Contact Staff

**Learning Goal(s):**

- provide information regarding the role of staff at mealtime/when feeding clients.
- provide information regarding the role of the O.T. in the context of mealtime.
- provide education concerning the appropriate use of feeding equipment.

**Teaching Method(s):** Lecture

**Time Required:** Return demonstration of feeding techniques  
1 hour

**Materials Used:** Adaptive Equipment for Mealtime, brought by O.T.

**Physical Setting:** Classroom

**Evaluation:** Class Participation  
Return demonstration of feeding techniques

A: FEEDING

**SUBJECT AREA:** Interdisciplinary Process

**PURPOSE:** To introduce the concept of Interdisciplinary Process

**TARGET AUDIENCE:** Direct Contact Staff

**LEARNING GOAL(S):**

- Develop familiarity with role of ID team members
- Provide information regarding the various systems which effect client care and training

**TEACHING METHOD(S):**

LECTURE

ROLE PLAY

**TIME:** One (1) hour

**MATERIALS USED:** Hand-outs of clinical agenda, clinical minutes

**EVALUATION:**

Class Participation

Role Play of ID Team Process



**Subject Area:** Active Treatment

**Purpose:** To define Active Treatment as continuous aggressive, consistent implementation of a program, and specialized and generic training.

**Audience:** Direct Contact Staff

**Learning Goal(s):** To familiarize staff with their role in providing active treatment for clients.

**Teaching Method(s):** Lecture

**Time Required:** 1 hour

**Materials Used:** Handouts, Videotape

**Evaluation:** Written Test/70%

A:ACTIVE

**SUBJECT AREA:** Crisis Management

**PURPOSE:** To provide trainees with techniques to use in a situation where a client is acting inappropriately and has no behavior program.

**AUDIENCE:** Direct Contact Staff

**LEARNING GOALS:**

- The trainee will become familiar with the basics of how crises get started.
- The trainee will become aware of what happens to people in crisis.
- The trainee will learn some questions to help guide them through a crisis.

**TEACHING METHOD(S)** Lecture

**TIME REQUIRED:** 1 hour

**MATERIALS USED:** Handouts, Videotape

**PHYSICAL SETTING:** Classroom

**EVALUATION:** CLASS PARTICIPATION

CRISIS

## TRAINING OUTLINE FORMAT

1. Title of Session: Client Record System (CRS)
2. Trainer(s): Chris Morin  
Back-up Trainer(s): Glenna Hatcher
3. Time Required: 1 hour and 15 minutes
4. Materials or Equipment Required: CRS and CRS Manuals
5. Site of Session: Building 4/Training Room
6. Learning Objectives for Participants in Training Session:
  - provide general overview of content and order of CRS
7. Instructor Guide or Outline of Training Session (be very specific so that back-up trainer could teach from it effectively). Attach any handouts used in session.
  1. Distribute materials
  2. Define CRS
  3. Content and Order of CRS
  4. Go through each section of CRS
  5. CRS manual
  6. Interdisciplinary (ID) Notes
    - define
    - how to write
    - confidentiality

EVALUATION:        TEST/70%

SUBJECT AREA: Data Collection

PURPOSE: Understand system for objectively gathering information on progress or lack of progress for client programs.

AUDIENCE: Direct Contact Staff

TIME REQUIRED: 1 hour 30 minutes

LEARNING GOAL(S): Understand the training plan for a client as written on the data form and correctly score or record client's participation and performance on the form.

TEACHING METHOD(S): Lecture  
Role Play

MATERIALS USED: Hand-outs  
Items for handwashing and dressing (shirt) programs

EVALUATION: Demonstrate recording data on Data Sheet

Subject Area: Behavior Modification #1  
Describing Behaviors/Behavioral Objectives  
Behavior Modification #2  
Observing and Recording Behaviors,  
Behavior Modification #3  
Increasing Behaviors: Reinforcers

Purpose: Introduce staff to behavior modification principles

Audience: Direct Contact Staff

Learning Goal(s):

1. Learn about behavior, behavior modification techniques, behavioral programming.
2. Using this information/training when working directly with clients

Teaching Method(s): Lecture

Time Required: 1 hour and 45 minutes

Materials Used: Hand-outs

Evaluation: Class Participation

BEHAVMOD

SUBJECT AREA: Behavior Modification  
Module V - Teaching Right Time/Right Place  
Module VI - Decreasing/Eliminating Behavior

PURPOSE: To gain familiarity with typical methods to  
modify maladaptive behavior..

AUDIENCE: Direct Contact Staff

LEARNING GOAL: Learn about behavior, behavior modification  
techniques, behavior programming

TEACHING METHOD(S): Lecture

TIME REQUIRED: 1 hour, 30 minutes

MATERIALS USED: Handouts

PHYSICAL SETTING: Classroom

EVALUATION: Class Participation

BEHAVVVI

## TRAINING OUTLINE FOR BEHAVIORAL DOCUMENTATION

**SUBJECT:** BEHAVIORAL DOCUMENTATION

**PURPOSE:** To acquaint staff with the method of documenting behavior program implementation

**AUDIENCE:** Direct Contact Staff

**LEARNING GOAL(S):**     -Explain importance of accurate documentation of behavior programs  
                              -Go over line by line the NVTC BEHAVIOR PROGRAM RECORD

**TEACHING METHODS:**     Lecture

**TIME REQUIRED:**         1 Hour

**MATERIALS USED:**       Handouts of Behavior Program Record

**EVALUATION:**           Use of form/return demonstration

**SUBJECT AREA:** Mechanical Device Procedures

**PURPOSE:** Give a overview of the types of mechanical devices used at NVTC

**AUDIENCE:** All Direct Contact Staff

**LEARNING GOAL(S)** -Instruct on reasons for mechanical devices  
-Show types of mechanical devices  
-Highlight safety measures

**TEACHING METHOD(S):** Lecture and Demonstration

**TIME REQUIRED:** 1 hour and 30 minutes

**MATERIALS USED:** Types of restraints

**EVALUATION:** Return demonstration/applying different mechanical devices



SUBJECT AREA: Behavior Modification: Wrap-Up "Harry"

PURPOSE: Illustrate points made in previous B-mod. sessions: Reinforcers, and Decreasing/Eliminating Behaviors

AUDIENCE: Direct, Contract Staff

LEARNING GOALS: Behavior changes occur as a result of consistent implementation of the programs by staff

TEACHING METHOD(S): Videotape, Discussion

TIME REQUIRED: 1 Hour, 15 Minutes

MATERIALS USED: Videotape: "Harry", handouts: Discussion guide and ten-year follow-up article

PHYSICAL SETTING: Classroom

EVALUATION: Class Participation

BHVWRAPUP

## TRAINING OUTLINE FORMAT

1. Title of Session: Missing Resident Policy / What is a Roving Team Leader (RTL)
2. Trainer(s): Carla Mills RTL  
Back-up Trainer(s): PM Developmental Technicians who have been passed off to rove.
3. Time Required: 1 Hour
4. Materials or Equipment Required: NVTC instruction 5000, Missing Resident Plan and procedures for Roving Team Leader and written test on Missing Resident Plan.
5. Site of Session: Building 4/Training Room
6. Learning Objectives for Participants in Training Session:
  1. Duties of RTL
  2. Missing Resident Procedures
7. Instructor Guide or Outline of Training Session (be very specific so that back-up trainer could teach from it effectively). Attach any handouts used in session.
  1. Names of RTL's (PM and NOC Shifts)
  2. RTL Responsibilities and Duties
  3. Missing Resident Plan and Procedure

TESTING - PENCIL AND PAPER

EM: Proman\msngres

**SUBJECT AREA:** Volunteer Services

**PURPOSE:** To acquaint new staff with department services

**AUDIENCE:** Direct Contact Staff

**LEARNING GOAL(S):**

- Educate staff on the value of volunteers
- Encourage them to participate in the volunteer program as volunteer supervisors or volunteers themselves.

**TEACHING METHOD:** Lecture

**TIME REQUIRED:** 1 Hour

**MATERIALS USED:** Flipchart, Handouts

**PHYSICAL SETTING:** Classroom

**EVALUATION:** Class Participation

VOLUNT1

## TRAINING OUTLINE FORMAT

1. Title of Session: Working with Families
2. Trainer(s): Alice Mary Hymel, ACSW  
Back-up Trainer(s): Leslie Katz
3. Time Required: 1-1/2 hours
4. Materials or equipment Required: VCR, Monitor and Video Tape
5. Site of Session: Building 4/Training Room
6. Learning Objectives for Participants in Training Session:
  - To inform and sensitize incoming employees of concerns, reactions, feelings and experiences of families. If possible, we have a family member tell of their experience of having a developmentally disabled family member.
7. Instructor Guide or Outline of Training Session (be very specific so that back-up trainer could teach from it effectively) Attach Any handouts used in session.
  - I. Overview of Families Reaction to a Developmentally Disabled Child, Sibling, etc.
    - a. developmental sequence experienced by family members
    - b. guilt, mourning, grief, anger, disappointment, jealousy
    - c. roles of new employee in working with family
    - d. possible problem situations/solutions
  - II. Family Presentation (ON VIDEO)
    - a) NVTC family presents their response, difficulties, actions, etc. in dealing with their developmentally disabled child
    - b) expectations of staff
  - III. Questions, Concerns, Feedback and Closure

EM: Proman\wrkfam

**Subject Area:** Human Sexuality

**Purpose:** Create a level of comfort discussing sexuality.

**Audience:** Direct Contact Staff

**Learning Goal(s):** Make trainees aware of NVTC sexuality policy

**Teaching Method(s):** Lecture, Discussion

**Time Required:** 2 Hours

**Materials Used:** Survey, handout:  
NVTC policy on sexuality/norms statement

**Physical Setting:** Classroom

**Evaluation:** Class Participation

A:HUMSEX

**SUBJECT AREA:** Therapeutic Recreation Services

**PURPOSE:** To acquaint new staff with therapeutic recreation services.

**AUDIENCE:** Direct Contact Staff

**LEARNING GOAL(S):**

- To educate trainees on the importance of recreation in meeting basic needs of people, specifically our clients.
- How meeting of these basic needs results in the enhancement of one's life, and improves self-esteem.
- Familiarize trainee with expectations, rules, and regulations of the pool, gym, and adult complex. And provide age-appropriate leisure options on the unit.

**TEACHING METHOD:** Lecture, Learning Activity

**TIME REQUIRED:** 1 hour

**MATERIALS USED:** Handouts, activity items, hula hoop, bean bags, cards.

**PHYSICAL SETTING:** Classroom

**EVALUATION:** Class Participation

## TRAINING OUTLINE FORMAT

1. Title of Session: Residential Services
2. Trainer(s): Mac McDonald  
Back-up Trainer(s): Program Managers
3. Time Required: 1-1/2 Hours
4. Materials or Equipment Required:
5. Site of Session: Building 4/Training Room
6. Learning Objectives for Participants in Training Session:
  - general orientation to Residential Services
  - basic "do's and don'ts"
  - introduce concept of Active Treatment
7. Instructor Guide or Outline of Training Session (be very specific so that back-up trainer could teach from it effectively). Attach any handouts used in session.

SEE ATTACHED

8. EVALUATION: CLASS PARTICIPATION

**SUBJECT AREA:** Direct Competency Training Program

**PURPOSE:** Introduce staff to the on unit training package

**AUDIENCE:** Direct Contact Staff

**LEARNING GOAL(S):** Show staff how to use training package to assist in learning jobs

**TEACHING METHODS:** Lecture  
Use of manuals

**TIME REQUIRED:** 1 hour

**MATERIALS REQUIRED:** Direct Care Competency Training Book  
Trainee Manuals  
Supervisors' Manual

**EVALUATION:** To be determined during probationary period



Direct Care Competency Training Program

The Direct Care Competency Training Program (DCCTP) is designed for new employees to provide a standardized competency based training tool. The training package is developed to orient new employees to their jobs; to list and document ability, skills and knowledge necessary to perform their duties. It will provide the trainee with enough technical information and practice to become a successful Developmental Aide, capable of performing all required duties and responsibilities.

In addition, DCCTP can be used in conjunction with an employee's performance evaluation. The supervision should review each of the competency items to ensure that the employee has maintained competency in each required area.

The Direct Care Competency Training Program has two parts: first, six (6) Learning Areas that are knowledge and information related to the Developmental Aide jobs description:

1. Orientation and Training
2. Philosophy
3. Personal Care, Health, Hygiene
4. Active Treatment
5. Documentation
6. Policy

The Learning Areas have objectives, questions, resources and performance criteria which may be a written test or return demonstration of the task. Each trainee will be required to successfully complete each Learning Area.

The second part is a list of competencies which are job duties that are task analyzed. They are divided into four (4) groups:

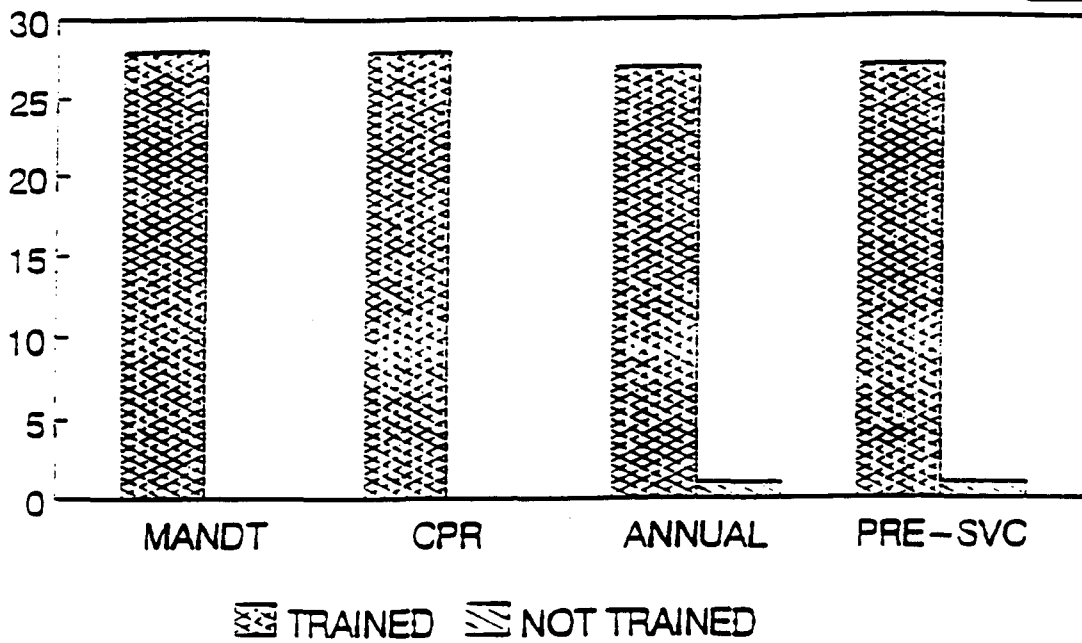
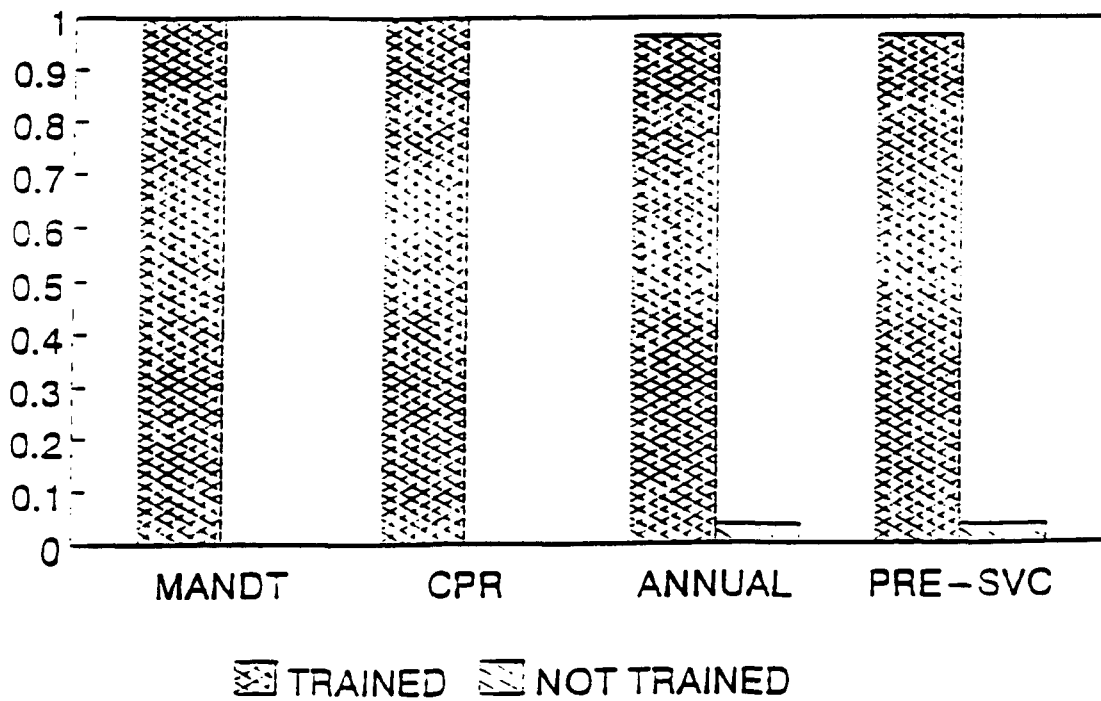
1. Provide Health Related Care
2. Staff/Client Interaction
3. Provide/Maintain Safe Living Area
4. Implement Program Plan

The task analyzed duties are used as resources in Learning Areas 3 and 4. The criteria for passing Learning Areas 3 and 4 is mastering the competencies by return demonstration of the task in the situation or a simulated situation as verbally recalling the procedure. The supervisor/trainer would document whether or not the trainee performs the task in an "acceptable" or "unacceptable" manner. The trainer should indicate under "comments" if the employee needs additional practice, training, or needs to attend Pre-Service Training Classes in related areas.

When the trainee reports to his/her unit after pre-service training, he/she will have a blue notebook which includes the six (6) Learning Areas. There is a book of competencies already on each unit. The Training Coordinator will have trainees work on and complete Learning Areas 1 and 2 while in training class. The trainer will then work exclusively on Learning Area 3 until he/she successfully completes the performance criteria. Since Learning Area 3 is so time-consuming, the maximum amount of time allowed to complete it will be three (3) months. Then go on in sequence to the other Learning Areas 4, 5, and 6; maximum amount of time allowed for each Learning Area will be one month. The trainee then can take up to six (6) months to complete the program.

The trainer will receive a notebook containing a Unit Competency Checklist, tests, answer sheets and task check sheets. The trainer will administer the performance criteria, be it written tests, performance check-offs, or both and document the results on the Unit Competency Checklist. This replaces NVTC form 162 Unit Training Checklist.

When the training is completed, the Unit Competency Training Checklist is reviewed and signed by the Team Leader and Program Manager and then sent to the Training office to be forwarded to Personnel with the Pre-Service Training Record.

UNIT 7C  
TRAINING STATUS OF STAFFUNIT 7C  
TRAINING STATUS OF STAFF

## Annual Re-Training Requirements for NVTC Staff

**Policy:** All employees will receive mandatory re-training in designated topics on an annual basis.

**Purpose:** The purpose of this re-training is to ensure competence in defined critical topic areas. The topics covered are determined to be important to allow staff to perform their duties in a manner which will protect themselves and the clients from injury.

**Schedule:** Re-training in the mandatory courses will be required annually; the anniversary month of the date of hire to the facility. Some courses are scheduled by the instructor with each department and are not included in the monthly Annual Re-training program.

**Required Training:** The following courses are required for the specified departments.

|                                   |                   |
|-----------------------------------|-------------------|
| Abuse Policy and Procedures       | All Staff         |
| Sexual Harassment                 | All Staff         |
| Infection Control Procedures/AIDS | All Staff         |
| Body Mechanics and Lifting        | All Staff         |
| Human Rights                      | All Staff         |
| Crisis Management                 | Direct Care Staff |
| Active Treatment                  | Direct Care Staff |

**Special Training Requirements:** In addition to the above training requirements for all staff, some classifications require additional training. All Clinical and Direct Care staff are required to be recertified in the Mandt System annually. If staff are in a position which requires CPR certification (direct care staff, STC staff, and recreation therapists) they must attend a recertification class annually.

**Responsibility:** It will be the responsibility of the Training Department to notify individual employees when they are scheduled to attend the Annual Re-training or recertification sessions. The Training Department will also notify the employee's supervisor so that schedule adjustments can be made, if necessary. It will be the responsibility of the individual employee to notify the Training Department if they are unable to attend the required classes.

**uation of Performance:** Each employee is expected to perform at his/her optimal level and is required to attend all mandatory classes. Performance in each session will be evaluated in the following ways:

1. Numerical score of 75% or better on written tests, or
2. Satisfactory demonstration of required skills, or
3. Participation/attendance in required classes

Any employee who does not perform satisfactorily in the required re-training sessions, will be notified in writing to repeat the session until competence is obtained. A copy of the written notification will also be sent to the individual's supervisor.

**Record of Training:** Upon successful completion of all required in-service training classes, the Training Department will document in the employee's computerized training record.

## EMERGENCY MEDICAL DRILLS

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**PURPOSE:** To establish a system for staff to review and/or practice appropriate responses to medical emergencies. Through mock emergency situations which simulate those most likely to occur in a particular work site, nursing and paraprofessional staff will be able to practice skills and agency procedures in medical emergencies.

**TARGET STAFF:** The primary staff required to participate in emergency drills will be unit nurses, CTR and infirmity staff, and unit direct care staff.

**RESPONSIBILITY:** The following staff will have designated responsibilities in ensuring that staff have adequate information and opportunity to practice and understand their role in a medical emergency on a monthly basis:

- Nurse Manager - communicate the requirements to the appropriate nurses; develop specific emergency situations/scenarios generic to different work sites; schedule BLS classes for nurses.

- Unit Nurses - coordinate scheduling of drills; select appropriate scenarios; process with participants afterwards.

- Direct Care Staff/Supervisors - participate in needed training for appropriate emergency medical care; participate in drills in preparation for real situations; process afterwards.

- Training Department - provide on-going CPR classes to direct care staff; assist in drills and processing as requested by unit nurses; document participation in individualized computerized training records.

**PROCEDURE:** See attached Emergency Medical Drills Procedure.

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# PROJECTED BUILDING 7 1995 TRAINING

| MONTH/TRAINING                           | DATE        | UNIT                         |
|------------------------------------------|-------------|------------------------------|
| <b>JANUARY</b>                           |             |                              |
| BM Routine                               | 1/24        | 7A/7C                        |
| New Fever Routine                        | 1/24        | 7A/7C                        |
| Nursing GOP for Seizures in Seizure Book | 1/24        | 7A/7C                        |
| <b>FEBRUARY</b>                          |             |                              |
| Family Centered Training (Part I)        | TBD         | 7A/7C                        |
| Mandt Review                             | 2/21        | 7C                           |
| Mandt Review                             | 2/23        | 7A                           |
| Active Treatment                         | 2/9         | 7A/7C                        |
| Active Treatment                         | 2/22        | 7A                           |
| <b>MARCH</b>                             |             |                              |
| Behavior Pass Off                        | TBD         | 7A-AM/PM                     |
| Mandt                                    | 2/21        | 7C                           |
| Mandt                                    | 2/23        | 7A                           |
| Seizures                                 | 2/28-2-2:45 | 7C-AM/PM                     |
| Seizures                                 | 2/30-2-2:45 | 7A-AM/PM                     |
| <b>APRIL</b>                             |             |                              |
| Behavior Pass Off                        | TBD         | 7C-AM/PM                     |
| Mandt                                    | 2/25        | 7C                           |
| Mandt                                    | 2/27        | 7A                           |
| CRS Training                             | TBD         | 7A/7C                        |
| CRS Training                             | TBD         | 7A/7C                        |
| Supervisory Training                     | TBD         | 7A/7C                        |
| <b>MAY</b>                               |             |                              |
| Sign Language                            | 5/2         | 7C/7A-AMs<br>(10:00 & 11:00) |
| Sign Language                            | 5/4         | 7C/7A-PMs<br>(1:30 & 2:30)   |
| Sign Language                            | TBD         | 7A/7C NOCs                   |
| Mandt Review                             | 5/23        | 7C                           |
| Mandt Review                             | 5/25        | 7A                           |

| MONTH/TRAINING                     | DATE  | UNIT                     |
|------------------------------------|-------|--------------------------|
| <b>JUNE</b>                        |       |                          |
| Emergency Response Training        | TBD   | 7A/7C-AMs                |
| Conflict Management                | TBD   | 7A/7C                    |
| Mandt Review                       | 6/20  | 7C                       |
| Mandt Review                       | 6/22  | 7A                       |
| Family Centered Training (Part II) | TBD   | 7A/7C                    |
| <b>JULY</b>                        |       |                          |
| Mandt Review                       | 7/25  | 7C                       |
| Mandt Review                       | 7/27  | 7A                       |
| <b>AUGUST</b>                      |       |                          |
| Mandt Review                       | 8/22  | 7C                       |
| Mandt Review                       | 8/24  | 7A                       |
| <b>SEPTEMBER</b>                   |       |                          |
| Behavior Pass Off                  | TBD   | 7A/7C                    |
| Mandt Review                       | 9/26  | 7C                       |
| Mandt Review                       | 9/28  | 7A                       |
| <b>OCTOBER</b>                     |       |                          |
| Behavior Pass Off                  | TBD   | 7A/7C                    |
| Mandt Review                       | 10/24 | 7C                       |
| Mandt Review                       | 10/26 | 7A                       |
| Family Centered Training           | 10/3  | 7C-10:00AM<br>7A-11:00AM |
| Family Centered Training           | 10/10 | 7C-1:30 PM<br>7A-2:30 PM |
| <b>NOVEMBER</b>                    |       |                          |
| Mandt Review                       | 11/14 | 7C                       |
| Mandt Review                       | 11/16 | 7A                       |
| <b>DECEMBER</b>                    |       |                          |
| Mandt Review                       | 12/12 | 7C                       |
| Mandt Review                       | 12/14 | 7A                       |
| Stress Management                  | TBD   | 7A/7C                    |

\*TBD = To be determined



CONTINUING EDUCATION REQUIREMENTS

Below are the minimum continuing education requirements established for NVTC clinical staff. These were established for professional positions for which there are no state mandated or licensing continuing education requirements. These were established by the appropriate Department Heads and were based on standards from other states.

| Position                 | Continuing Education Requirement                                                                                                       |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Administrator            | -20 hours per year                                                                                                                     |
| Dental Department*       | -1 CE meeting per year at DC Dental Society Spring meeting<br>-In-house in-services provided by dentist                                |
| Nursing*                 | -3 NVTC in-services per year<br>-12 contact hours by completing a home study program                                                   |
| Occupational Therapist*  | -3 hours per year (conferences, in-services, assistance centers, facility tours, academic courses)                                     |
| Physical Therapist*      | -15 hours per year                                                                                                                     |
| Physicians               | -90 hours of CME every 3 years                                                                                                         |
| Psychologist*            | -60 CEU hours every 2 years                                                                                                            |
| Radiologic Technologist* | -3 sessions per year                                                                                                                   |
| Recreation Therapist     | -Community CPR (annual)<br>-Lifeguarding (every 3 years)<br>-Pool Operators (one time)<br>-10 hours T.R. coursework or in-service/year |
| Social Worker            | -Workshops, etc - 16 hrs/year<br>-Professional meetings - 10 hrs/yr<br>-Self-directed study - 3 hrs/year                               |

Speech Therapist  
Audiologist

- Reading ASHA publications and sharing info at department meeting
- Reading "Clinical Connection"
- Attending local workshops
- Attending 2 professional meetings per year

\* No state CME/CEU requirements established

**PROPOSED RESIDENTIAL/CLINICAL SERVICES PRIORITIZED EQUIPMENT LIST  
FROM FY '95 - '96**

appx

91  
ATTACHMENT

February 27, 1995

| Equipment Name<br>By Description | Region | Qty | Unit Price | Price       | Available Balance | Ordered | Revised |
|----------------------------------|--------|-----|------------|-------------|-------------------|---------|---------|
|                                  |        |     |            |             | \$150,000.00      |         |         |
| <b>PHYSICAL THERAPY</b>          |        |     |            |             |                   |         |         |
| Wheelchairs - Electric           |        | 6   | \$800.00   | \$4,800.00  | \$145,200.00      |         |         |
| Seating Systems<br>f/wheelchairs |        | 6   | \$1,200.00 | \$7,200.00  | \$138,000.00      |         |         |
| Tilt-in-space Wheelchairs        |        | 8   | \$2,083.00 | \$16,664.00 | \$121,336.00      |         |         |
| Seating f/wheelchairs            |        | 8   | \$1,200.00 | \$9,600.00  | \$111,736.00      |         |         |
| Reclining Wheelchairs            |        | 4   | \$2,837.00 | \$11,348.00 | \$100,388.00      |         |         |
| Seating system<br>f/wheelchairs  |        | 4   | \$1,200.00 | \$4,800.00  | \$95,588.00       |         |         |
| Wheelchairs, regular<br>manual   |        | 8   | \$2,030.00 | \$16,240.00 | \$79,348.00       |         |         |
| Seating system<br>f/wheelchairs  |        | 8   | \$500.00   | \$4,000.00  | \$75,348.00       |         |         |
| <b>POSITIONING<br/>EQUIPMENT</b> |        | 0   | \$0.00     | \$0.00      | \$75,348.00       |         |         |
| Rifton Lift Walker               |        | 1   | \$1,995.00 | \$1,995.00  | \$73,353.00       |         |         |
| Rifton Prone Stander             |        | 1   | \$1,200.00 | \$1,200.00  | \$72,153.00       |         |         |
| Rifton Supine Stander            |        | 1   | \$1,200.00 | \$1,200.00  | \$70,953.00       |         |         |

| Rifton Adult Gait Trainer                                                           |  | 2  | \$870.00   | \$1,740.00  | \$69,213.00 |  |  |
|-------------------------------------------------------------------------------------|--|----|------------|-------------|-------------|--|--|
| Rifton Sidelyers                                                                    |  | 2  | \$439.00   | \$878.00    | \$68,335.00 |  |  |
| Rifton Mobil Stander                                                                |  | 1  | \$1,723.00 | \$1,723.00  | \$66,612.00 |  |  |
| Night-time Sidelyers                                                                |  | 20 | \$105.00   | \$2,100.00  | \$64,512.00 |  |  |
| Droff-off Wedge Sets                                                                |  | 8  | \$2,400.00 | \$19,200.00 | \$45,312.00 |  |  |
| Incline Wedges                                                                      |  | 10 | \$115.00   | \$1,150.00  | \$44,162.00 |  |  |
| Supine Leg Supports                                                                 |  | 10 | \$120.00   | \$1,200.00  | \$42,962.00 |  |  |
| Head Supports                                                                       |  | 15 | \$70.00    | \$1,050.00  | \$41,912.00 |  |  |
| <b>SPEECH &amp; HEARING</b>                                                         |  |    |            | \$0.00      | \$41,912.00 |  |  |
| SCAN-A Test f/Auditory Processing Disorders                                         |  | 1  | \$100.00   | \$100.00    | \$41,812.00 |  |  |
| Auditory Continuous Performance Test                                                |  | 1  | \$100.00   | \$100.00    | \$41,712.00 |  |  |
| Auditory Enhancement Training -VA Foundation for the Exceptional Child & Adolescent |  | 3  | \$750.00   | \$2,250.00  | \$39,462.00 |  |  |
| Custom Audio Design Room System                                                     |  | 1  | \$735.00   | \$735.00    | \$38,727.00 |  |  |
| Computer Table                                                                      |  | 1  | \$400.00   | \$400.00    | \$38,327.00 |  |  |
| Recumbent/recling chair                                                             |  | 1  | \$500.00   | \$500.00    | \$37,827.00 |  |  |
| Attendant seating (chairs)                                                          |  | 4  | \$125.00   | \$500.00    | \$37,327.00 |  |  |
| Wheelchair ramp to test room                                                        |  | 2  | \$100.00   | \$200.00    | \$37,127.00 |  |  |

| Item                                                                                              | Quantity | Unit Price | Subtotal   | Balance       | Balance | Balance | Balance |
|---------------------------------------------------------------------------------------------------|----------|------------|------------|---------------|---------|---------|---------|
| <b>Training Department</b>                                                                        | 0        | \$0.00     | \$0.00     | \$3,027.00    |         |         |         |
| Satellite Network System                                                                          | 1        | \$6,700.00 | \$6,700.00 | (\$3,673.00)  |         |         |         |
| Physical Management Training Program Package (Manuals & Training Books)                           | 1        | \$3,800.00 | \$3,800.00 | (\$7,473.00)  |         |         |         |
| Contract for Physical Management Training Program Master Trainer to train NVT C in-house Trainers | 1        | \$5,000.00 | \$5,000.00 | (\$12,473.00) |         |         |         |
| Clinical Presentations                                                                            | 1        | \$2,500.00 | \$2,500.00 | (\$14,973.00) |         |         |         |
| Training Packages on Supervisory/Management Topics & Cultural Diversity                           | 1        | \$2,500.00 | \$2,500.00 | (\$17,473.00) |         |         |         |
| <b>Nutrition Services</b>                                                                         |          |            | \$0.00     | (\$17,473.00) |         |         |         |
| Weighing Scales                                                                                   | 1        | \$700.00   | \$700.00   | (\$18,173.00) |         |         |         |
| Specialized Calipers (to assess nutritional status)                                               | 4        | \$350.00   | \$1,400.00 | (\$19,573.00) |         |         |         |
| Measuring Boards                                                                                  | 2        | \$600.00   | \$1,200.00 | (\$20,773.00) |         |         |         |
| Adaptive Equipment                                                                                | 1        | \$4,000.00 | \$4,000.00 | (\$24,773.00) |         |         |         |
| Workshops                                                                                         | 2        | \$400.00   | \$800.00   | (\$25,573.00) |         |         |         |
| Subscriptions (Pediatrics & Dysphagia)                                                            | 1        | \$500.00   | \$500.00   | (\$26,073.00) |         |         |         |
| Intensive Feeding Etc                                                                             | 1        | \$350.00   | \$350.00   | (\$26,423.00) |         |         |         |

| Equipment                                                           | Quantity | Unit Price | Subtotal   | Grand Total | Balance | Notes |
|---------------------------------------------------------------------|----------|------------|------------|-------------|---------|-------|
| Shelf f/audio equipment                                             | 1        | \$200.00   | \$200.00   | \$36,927.00 |         |       |
| Desk f/audio equipment                                              | 1        | \$300.00   | \$300.00   | \$36,627.00 |         |       |
| Bookshelves f/RM. 247B                                              | 2        | \$200.00   | \$400.00   | \$36,227.00 |         |       |
| Filing Cabinets                                                     | 3        | \$200.00   | \$600.00   | \$35,627.00 |         |       |
| Chairs (Upholstered)                                                | 4        | \$125.00   | \$500.00   | \$35,127.00 |         |       |
| SCAN-Screening Test<br>f/Auditory Processing<br>Disorders Ages 3-11 | 1        | \$100.00   | \$100.00   | \$35,027.00 |         |       |
| Audio Enhancer/Trainer                                              | 1        | \$5,000.00 | \$5,000.00 | \$30,027.00 |         |       |
| Unit-based IBM or Apple<br>computer<br>(w/peripherals)              | 1        | \$5,000.00 | \$5,000.00 | \$25,027.00 |         |       |
|                                                                     |          |            | \$0.00     | \$25,027.00 |         |       |
| Occupational Theray                                                 |          |            | \$0.00     | \$25,027.00 |         |       |
| Electronic Feed Device                                              | 2        | \$2,000.00 | \$4,000.00 | \$21,027.00 |         |       |
| ADL Supplies                                                        | 1        | \$700.00   | \$700.00   | \$20,327.00 |         |       |
| Splinting Equip                                                     | 1        | \$2,500.00 | \$2,500.00 | \$17,827.00 |         |       |
| Sensory Stimulation<br>Equipment                                    | 1        | \$4,600.00 | \$4,600.00 | \$13,227.00 |         |       |
| Sensory Integration<br>Equipment                                    | 1        | \$2,100.00 | \$2,100.00 | \$11,127.00 |         |       |
| Adaptive Switches &<br>Devises                                      | 1        | \$8,000.00 | \$8,000.00 | \$3,127.00  |         |       |
| Measurement Devices                                                 | 1        | \$100.00   | \$100.00   | \$3,027.00  |         |       |
|                                                                     | 0        | \$0.00     | \$0.00     | \$3,027.00  |         |       |

**PROPOSED RESIDENTIAL/CLINICAL SERVICES PRIORITISED EQUIPMENT LIST**  
FROM FY '95 - '96

16

February 27, 1995

| Equipment List<br>By Priority    | Requester | Qty | Unit Price | Price       | Available<br>Balance | ORDERED | RECD |
|----------------------------------|-----------|-----|------------|-------------|----------------------|---------|------|
|                                  |           |     |            |             | \$150,000.00         |         |      |
| <b>PHYSICAL THERAPY</b>          |           |     |            |             |                      |         |      |
| Wheelchairs - Electric           |           | 6   | \$800.00   | \$4,800.00  | \$145,200.00         |         |      |
| Seating Systems<br>f/wheelchairs |           | 6   | \$1,200.00 | \$7,200.00  | \$138,000.00         |         |      |
| Tilt-inpace Wheelchairs          |           | 8   | \$2,083.00 | \$16,664.00 | \$121,336.00         |         |      |
| Seating f/wheelchairs            |           | 8   | \$1,200.00 | \$9,600.00  | \$111,736.00         |         |      |
| Reclining Wheelcharis            |           | 4   | \$2,837.00 | \$11,348.00 | \$100,388.00         |         |      |
| Seating system<br>f/wheelchairs  |           | 4   | \$1,200.00 | \$4,800.00  | \$95,588.00          |         |      |
| Wheelchairs, regular<br>manual   |           | 8   | \$2,030.00 | \$16,240.00 | \$79,348.00          |         |      |
| Seating system<br>f/wheelchairs  |           | 8   | \$500.00   | \$4,000.00  | \$75,348.00          |         |      |
| <b>POSITIONING<br/>EQUIPMENT</b> |           | 0   | \$0.00     | \$0.00      | \$75,348.00          |         |      |
| Rifton Lift Walker               |           | 1   | \$1,995.00 | \$1,995.00  | \$73,353.00          |         |      |
| Rifton Prone Stander             |           | 1   | \$1,200.00 | \$1,200.00  | \$72,153.00          |         |      |
| Rifton Supine Stander            |           | 1   | \$1,200.00 | \$1,200.00  | \$70,953.00          |         |      |

| Equipment List<br>By Priority                                                       | Quantity | Unit Price | Price       | Available Balance | Ordered | Balance |
|-------------------------------------------------------------------------------------|----------|------------|-------------|-------------------|---------|---------|
| Rifton Adult Gait Trainer                                                           | 2        | \$870.00   | \$1,740.00  | \$69,213.00       |         |         |
| Rifton Sidelyers                                                                    | 2        | \$439.00   | \$878.00    | \$68,335.00       |         |         |
| Rifton Mobil Stander                                                                | 1        | \$1,723.00 | \$1,723.00  | \$66,612.00       |         |         |
| Night-time Sidelyers                                                                | 20       | \$105.00   | \$2,100.00  | \$64,512.00       |         |         |
| Droff-off Wedge Sets                                                                | 8        | \$2,400.00 | \$19,200.00 | \$45,312.00       |         |         |
| Incline Wedges                                                                      | 10       | \$115.00   | \$1,150.00  | \$44,162.00       |         |         |
| Supine Leg Supports                                                                 | 10       | \$120.00   | \$1,200.00  | \$42,962.00       |         |         |
| Head Supports                                                                       | 15       | \$70.00    | \$1,050.00  | \$41,912.00       |         |         |
| <b>SPEECH &amp; HEARING</b>                                                         |          |            | \$0.00      | \$41,912.00       |         |         |
| SCAN-A Test f/Auditory Processing Disorders                                         | 1        | \$100.00   | \$100.00    | \$41,812.00       |         |         |
| Auditory Continuous Performance Test                                                | 1        | \$100.00   | \$100.00    | \$41,712.00       |         |         |
| Auditory Enhancement Training -VA Foundation for the Exceptional Child & Adolescent | 3        | \$750.00   | \$2,250.00  | \$39,462.00       |         |         |
| Custom Audio Design Room System                                                     | 1        | \$735.00   | \$735.00    | \$38,727.00       |         |         |
| Computer Table                                                                      | 1        | \$400.00   | \$400.00    | \$38,327.00       |         |         |
| Recumbent/reclining chair                                                           | 1        | \$500.00   | \$500.00    | \$37,827.00       |         |         |
| Attendant seating (chairs)                                                          | 4        | \$125.00   | \$500.00    | \$37,327.00       |         |         |
| Wheelchair ramp to testbooth                                                        | 2        | \$100.00   | \$200.00    | \$37,127.00       |         |         |



| Equipment Name<br>By Priority                                                                     | Quantity | Unit Price | Price      | Available Balance | Ordered | Remaining |
|---------------------------------------------------------------------------------------------------|----------|------------|------------|-------------------|---------|-----------|
| <b>Training Department</b>                                                                        | 0        | \$0.00     | \$0.00     | \$3,027.00        |         |           |
| Satellite Network System                                                                          | 1        | \$6,700.00 | \$6,700.00 | (\$3,673.00)      |         |           |
| Physical Management Training Program Package (Manuals & Training Books)                           | 1        | \$3,800.00 | \$3,800.00 | (\$7,473.00)      |         |           |
| Contract for Physical Management Training Program Master Trainer to train NVT C in-house Trainers | 1        | \$5,000.00 | \$5,000.00 | (\$12,473.00)     |         |           |
| Clinical Presentations                                                                            | 1        | \$2,500.00 | \$2,500.00 | (\$14,973.00)     |         |           |
| Training Packages on Supervisory/Management Topics & Cultural Diversity                           | 1        | \$2,500.00 | \$2,500.00 | (\$17,473.00)     |         |           |
| <b>Nutrition Services</b>                                                                         |          |            | \$0.00     | (\$17,473.00)     |         |           |
| Weighing Scales                                                                                   | 1        | \$700.00   | \$700.00   | (\$18,173.00)     |         |           |
| Specialized Calipers (to assess nutritional status)                                               | 4        | \$350.00   | \$1,400.00 | (\$19,573.00)     |         |           |
| Measuring Boards                                                                                  | 2        | \$600.00   | \$1,200.00 | (\$20,773.00)     |         |           |
| Adaptive Equipment                                                                                | 1        | \$4,000.00 | \$4,000.00 | (\$24,773.00)     |         |           |
| Workshops                                                                                         | 2        | \$400.00   | \$800.00   | (\$25,573.00)     |         |           |
| Subscriptions (Pediatrics & Dysphagia)                                                            | 1        | \$500.00   | \$500.00   | (\$26,073.00)     |         |           |
| Intensive Feeding Program                                                                         | 1        | \$350.00   | \$350.00   | (\$26,423.00)     |         |           |

| Equipment Line<br>By Priority                                       | Quantity | Qty | Unit Price | Price      | Available<br>Balance | ORDERED | RECD |
|---------------------------------------------------------------------|----------|-----|------------|------------|----------------------|---------|------|
| Shelf f/audio equipment                                             |          | 1   | \$200.00   | \$200.00   | \$36,927.00          |         |      |
| Desk f/audio equipment                                              |          | 1   | \$300.00   | \$300.00   | \$36,627.00          |         |      |
| Bookshelves f/RM. 247B                                              |          | 2   | \$200.00   | \$400.00   | \$36,227.00          |         |      |
| Filing Cabinets                                                     |          | 3   | \$200.00   | \$600.00   | \$35,627.00          |         |      |
| Chairs (Upholstered)                                                |          | 4   | \$125.00   | \$500.00   | \$35,127.00          |         |      |
| SCAN-Screening Test<br>f/Auditory Processing<br>Disorders Ages 3-11 |          | 1   | \$100.00   | \$100.00   | \$35,027.00          |         |      |
| Audio Enhancer/Trainer                                              |          | 1   | \$5,000.00 | \$5,000.00 | \$30,027.00          |         |      |
| Unit-based IBM or Apple<br>computer<br>(w/peripherals)              |          | 1   | \$5,000.00 | \$5,000.00 | \$25,027.00          |         |      |
|                                                                     |          |     |            | \$0.00     | \$25,027.00          |         |      |
| Occupational Theray                                                 |          |     |            | \$0.00     | \$25,027.00          |         |      |
| Electronic Feed Device                                              |          | 2   | \$2,000.00 | \$4,000.00 | \$21,027.00          |         |      |
| ADL Supplies                                                        |          | 1   | \$700.00   | \$700.00   | \$20,327.00          |         |      |
| Splinting Equip                                                     |          | 1   | \$2,500.00 | \$2,500.00 | \$17,827.00          |         |      |
| Sensory Stimulation<br>Equipment                                    |          | 1   | \$4,600.00 | \$4,600.00 | \$13,227.00          |         |      |
| Sensory Integration<br>Equipment                                    |          | 1   | \$2,100.00 | \$2,100.00 | \$11,127.00          |         |      |
| Adaptive Switches &<br>Devises                                      |          | 1   | \$8,000.00 | \$8,000.00 | \$3,127.00           |         |      |
| Measurement Devices                                                 |          | 1   | \$100.00   | \$100.00   | \$3,027.00           |         |      |
|                                                                     |          | 0   | \$0.00     | \$0.00     | \$3,027.00           |         |      |

- I. The purpose of this Request for Proposals is to solicit sealed proposals from qualified sources to establish a contract, through competitive negotiations for consulting services in the areas of dysphagia and nutrition management, for Northern Virginia Training Center an agency of the Commonwealth of Virginia.

II. Background: The Northern Virginia Training Center is an agency of the Department of Mental Health, Mental Retardation, and Substance Abuse Services of the Commonwealth of Virginia. Located in Fairfax County on an 86 acre campus the Training Center is a residential facility for approximately 250 severely retarded clients with multiple handicaps and disorders. The Training Center provides a complete milieu of medical, psychological, recreational, occupational and other therapeutic services. To arrange for a site visit or for additional information about the facility please contact Mr. Leon Rose at 703-323-4007.

A. Statement of Need: The Contractor shall provide services and meet the qualifications as listed below:

1. The Contractor shall have demonstrable experience, in providing consulting services in the areas of dysphagia and nutritional management with an adult population of developmentally disabled and mentally retarded individuals in both institutional and community settings.
2. The Contractor shall work with the Agency's Dysphagia Committee to achieve the following goals:
  - a. To assist in the establishment of policies and procedures which can be practically implemented and practiced by Agency clinicians and direct care staff.
  - b. The policies and procedures shall assist in the development of the scope of responsibilities of the committee as an adjunct to the Interdisciplinary Team (ID

Team). These policies/procedures shall include but not be limited to:

- (1) Improving nutrition risk screening assessments.
  - (2) Involvement and education of parents when recommendations are made.
  - (3) Follow up procedures for recommendations made by the Committee and/or outside consultants.
  - (4) Establishing relationships with community resources which shall address but not be limited to the area of diagnostic testing.
  - (5) Establish policies in the area of tube feeding management.
3. The Contractor shall provide training to further establish the Agency Dysphagia Committee in the clarification of the individual roles and responsibilities of each clinical discipline on the team.
  4. The Contractor shall provide case study reviews of 4/5 Agency clients.
  5. The Contractor shall provide one training session to Agency direct care staff on dysphagia and related feeding problems of Agency clients. This training shall include but not be limited to the following:
    - a. A basic overview of dysphagia and mealtime difficulties with this type of client population.

- b. An overview of how the feeding programs are designed and why the proper implementation of feeding programs is required.
  - c. Proper positioning during implementation of the program.
  - d. Proper use of adaptive feeding equipment.
  - e. Mealtime management issues including both food consistencies and thickener use.
  - f. Reflux/rumination management.
  - g. Oral desensitization and stimulation.
6. The Contractor shall provide consultation and training to Agency clinicians in the following areas:
- a. Oral motor screening and assessment.
  - b. Oral desensitization and stimulation, including a program design for enteral feeding with oral testing.
  - c. Nutrition risk assessment and intervention.
  - d. Mealtime management issues including food consistencies and thickener use.
  - e. Reflux/rumination management.
  - f. Establish quality assurance in clinical management of nutrition/dysphagia.
  - g. Establish a quality assurance program for ongoing competency based training program to be used with direct care staff on feeding and positioning difficulties.

- i. Assist in the development of procedures and appropriate documentation with the purpose of avoiding negligence regarding feeding and hydration issues.
  - j. Rehabilitation techniques to increase compensatory strategies and enhance airway protection, including medication administration with dysphasic individuals.
- B. The Contractor shall consent to the video recording of any and all training sessions provided to Agency staff. All video recordings shall become the property of the Agency and will be for Agency use only.
- C. The Contractor shall provide telephone consultations for each discipline after the initial inservice at a cost to be determined. The Agency will coordinate all additional consultations through the Contract Manager (Director of Nursing).
- D. The Contractor shall agree to provide additional follow up sessions for either individual disciplines or for the entire group, on an as needed basis, as required by the Agency at a cost to be determined. The Agency will coordinate all additional consultations through the Contract Manager.
- E. The Contractor shall plan and coordinate the entire project with the Contract Manager.
- F. Articles published by the Contractor during or after the period of the contract shall have the written permission of the Agency Director and shall give credit to the Agency if any of the information in the article evolves from the Agency.

**RESIDENTIAL/CLINICAL SERVICES PRIORITIZED EQUIPMENT LIST**  
**FROM FY '93 - '94 RETURN YEAR END MONEY**  
**February 24, 1995**

81  
 ATTACHMENT

| Equipment                       | Requester        | Qty | Unit Price | Price      | Available Balance | Ordered | Rec'd |
|---------------------------------|------------------|-----|------------|------------|-------------------|---------|-------|
|                                 |                  |     |            |            | \$113,000.00      |         |       |
| <b>PHYSICAL THERAPY</b>         |                  |     |            |            |                   |         |       |
| Puritan-Bennett Percussor       | P.T. (Unit 1)    | 1   | \$450.00   | \$450.00   | \$112,550.00      | X       |       |
| Positioning Chairs for Mealtime | P.T. - (Bldg. 3) | 30  | \$177.30   | \$5,319.00 | \$107,231.00      | X       | X     |
|                                 |                  |     |            |            |                   |         |       |
| <b>OCCUPATIONAL THERAPY</b>     |                  |     |            |            |                   |         |       |
| Sensory Integration             | O.T.             | 1   | \$2,041.02 | \$2,041.02 | \$105,189.98      | X       |       |
| T.V. Monitor                    | O.T.             | 1   | \$369.96   | \$369.96   | \$104,820.02      | X       |       |
| VCR - video-fluoroscopies       | O.T.             | 1   | \$525.00   | \$525.00   | \$104,295.02      | X       | X     |
| Cart (f/monitor & VCR)          | O.T.             | 1   | \$109.00   | \$109.00   | \$104,186.02      | X       | X     |
| Portable Forma-Splinting Pan    | O.T.             | 1   | \$594.00   | \$594.00   | \$103,592.02      | X       |       |
| <b>SPEECH &amp; HEARING</b>     |                  |     |            |            |                   |         |       |
| Board Maker                     | Speech           | 1   | \$399.00   | \$399.00   | \$103,193.02      | X       | X     |
| Board Maker Supplies            | Speech           | 1   | \$350.00   | \$350.00   | \$102,843.02      | X       | X     |
| Color Ink Jet Printer           | Speech           | 1   | \$315.00   | \$315.00   | \$102,528.02      | X       | X     |
|                                 |                  |     |            |            |                   |         |       |
|                                 |                  |     |            |            |                   |         |       |

| Item Description                                                         | Category   | Qty | Unit Price | Total Price | Amount       | Ordered | Received |
|--------------------------------------------------------------------------|------------|-----|------------|-------------|--------------|---------|----------|
| <b>AUGMENTATIVE DEVICES LISTED BELOW</b>                                 |            |     |            |             |              |         |          |
| Speak Easy AlbeNet w/keyguard                                            | Speech     | 3   | \$383.00   | \$1,149.00  | \$101,379.02 | X       | X        |
| Hawk AdamLab                                                             | Speech     | 2   | \$175.00   | \$350.00    | \$101,029.02 | X       | X        |
| Cybersmith's VRA System VI-Deluxe Bioacoustics, Inc                      | Audiology  | 1   | \$1,200.00 | \$1,200.00  | \$99,829.02  | X       |          |
| DynaVox Augmentative Advice                                              | Speech     | 1   | \$4,525.00 | \$4,525.00  | \$95,304.02  | X       | X        |
| Walker-Talker Prentke-Romich                                             | Speech     | 1   | \$1,543.00 | \$1,543.00  | \$93,761.02  | X       | X        |
| Alpha Talker with Headset + 4 & 8 location operating kits Prentke-Romich | Speech     | 1   | \$1,495.00 | \$1,495.00  | \$92,266.02  | X       | X        |
| Shelving for Augmentative/Assistive Library                              | Speech     | 1   | \$1,067.00 | \$1,067.00  | \$91,199.02  | X       |          |
| <b>RECREATION</b>                                                        |            |     |            |             |              |         |          |
| Basketball Rim/Hoop                                                      | Recreation | 1   | \$700.00   | \$700.00    | \$90,499.02  | X       |          |
| Tent (large 2 rms.)                                                      | Recreation | 1   | \$299.00   | \$299.00    | \$90,200.02  | X       |          |
| Tent (small)                                                             | Recreation | 1   | \$70.00    | \$70.00     | \$90,130.02  | X       | X        |
| Roller Skates                                                            | Recreation | 8   | \$40.00    | \$320.00    | \$89,810.02  | X       | X        |
| Sleeping Bags                                                            | Recreation | 8   | \$28.00    | \$224.00    | \$89,586.02  | X       |          |
| Padded Folding Chairs                                                    | Recreation | 32  | \$12.60    | \$403.20    | \$89,182.82  | X       | X        |
| Chair Rack                                                               | Recreation | 1   | \$283.00   | \$283.00    | \$88,899.82  |         | X        |



| Equipment/Services                         |                                        | Quantity | Unit Price  | Subtotal    | Total Price | Building | Room |
|--------------------------------------------|----------------------------------------|----------|-------------|-------------|-------------|----------|------|
| <b>PSYCHOLOGY</b>                          |                                        |          |             |             |             |          |      |
| Video Camera<br>(w/accessories )           | Psychology                             | 1        | \$1,117.50  | \$1,117.50  | \$87,782.32 | X        | X    |
| VCR                                        | Psychology                             | 1        | \$525.00    | \$525.00    | \$87,257.32 | X        | X    |
| Cart (f/monitor &<br>VCR)                  | Psychology                             | 1        | \$109.23    | \$109.23    | \$87,148.09 | X        | X    |
| Stat/Graphic Computer<br>Software Pkg.     | Psychology                             | 1        | \$800.00    | \$800.00    | \$86,348.09 |          |      |
| Desk                                       | Psy (2)                                | 2        | \$253.00    | \$506.00    | \$85,842.09 | X        |      |
| TV Monitor                                 | Psychology                             | 1        | \$369.96    | \$369.96    | \$85,472.13 | X        |      |
| <b>RESIDENTIAL SERVICES</b>                |                                        |          |             | \$0.00      | \$85,472.13 |          |      |
| <b>EQUIPMENT/SERVICES</b>                  |                                        |          |             | \$0.00      | \$85,472.13 |          |      |
| Nutritional Consultant<br>Management Team  |                                        | 1        | \$15,000.00 | \$15,000.00 | \$70,472.13 | X        |      |
| Mats for Quiet Rooms<br>(Closed cell foam) | Bldg. 5, 6, 7, 8<br>all quiet rooms    | 12       | \$170.60    | \$2,047.20  | \$68,424.93 | X        |      |
| Desk                                       | Bldg. 3 (10,<br>Bldg. 5 (1)            | 2        | \$253.00    | \$506.00    | \$67,918.93 | X        |      |
| Computer Tables                            | Bldg. 3 (1),<br>5 (3), 6 (2), 7<br>(1) | 7        | \$150.00    | \$1,050.00  | \$66,868.93 | X        |      |
| Printers - Ink                             | Bldg. 3 (1),<br>5 (20, 7 (1),<br>891)  | 5        | \$256.41    | \$1,282.05  | \$65,586.88 | X        | X    |
| Printers - Laser                           | Bldg. 6 (10,<br>7 (10, 891)            | 3        | \$500.00    | \$1,500.00  | \$64,086.88 |          |      |
| Med.<br>on Carts                           | Bldgs. 1, 3, 5,<br>6, 7, 8,            | 11       | \$1,000.00  | \$11,000.00 | \$53,086.88 |          |      |

| <b>FURNITURE</b>             |                                                                     |    |            |             |             |   |   |
|------------------------------|---------------------------------------------------------------------|----|------------|-------------|-------------|---|---|
| Table (End)                  | Bdlg. 6                                                             | 10 | \$284.50   | \$2,845.00  | \$50,241.88 | X |   |
| Television (20")             | Bldg. - 6(2),<br>7(1),                                              | 1  | \$210.00   | \$210.00    | \$50,031.88 | X | X |
| Television (24' Console)     | Bldg. 3 91)                                                         | 1  | \$330.00   | \$330.00    | \$49,701.88 | X | X |
| Entertainment Cabinets       | Bldg. - 3(6),<br>5(3), 6(3),<br>7(4), 8(4)                          | 21 | \$800.00   | \$16,800.00 | \$32,901.88 |   |   |
| Chairs (Office &<br>Recliner | *Unit 1(2<br>Recliners)<br>Bldg. 6<br>(4roller/4 arm)<br>***hold*** | 4  | \$479.50   | \$1,918.00  | \$30,983.88 |   |   |
| <b>HOME FURNISHING</b>       | \$30,983.88                                                         |    |            |             |             |   |   |
|                              |                                                                     |    |            |             |             |   |   |
| Unit 1 Ambience              |                                                                     | 1  | \$1,000.00 | \$1,000.00  | \$29,983.88 | X | X |
| Bldg. 3 Ambience             |                                                                     | 1  | \$3,000.00 | \$3,000.00  | \$26,983.88 | X | X |
| Bldg. 5 Ambience             |                                                                     | 1  | \$3,000.00 | \$3,000.00  | \$23,983.88 | X | X |
| Bldg. 6 Ambience             |                                                                     | 1  | \$2,000.00 | \$2,000.00  | \$21,983.88 | X | X |
| Bldg. 7 Ambience             |                                                                     | 1  | \$1,000.00 | \$1,000.00  | \$20,983.88 | X | X |
| Bldg. 8 Ambience             |                                                                     | 1  | \$1,000.00 | \$1,000.00  | \$19,983.88 | X | X |
|                              |                                                                     |    |            | \$0.00      | \$19,983.88 |   |   |
|                              |                                                                     |    |            | \$0.00      | \$19,983.88 |   |   |

| 1995                                                                                          | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
|-----------------------------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| <b>NEUROLOGY</b><br>Tues, 2x mo<br>7 pm<br>Joeker 352-6996                                    |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>ENT</b><br>4th Thurs/mo<br>9:30 am<br>Dr. Rooney 281-2266                                  |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>ORTHOPEDIC</b><br>3rd Fri/mo<br>1:00 pm<br>Dr. Rogers 998-1110                             |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>OPHTHALMOLOGY</b><br>4th Tues q2 mo<br>2:30 pm / 1:30 eye drops<br>Dr. Forster FC 334-3900 |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>PHYSIATRY</b><br>Mon q2 mo<br>9:30 am<br>Dr. Gashi 938-5744                                |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>GI</b><br>last Monday q2 mo<br>9:30 am<br>Dr. Fischer 860-1700                             |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>PODIATRY</b><br>Wed q2 mo<br>pm<br>Greiner 941-7770                                        |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>UROLOGY</b><br>Last Wed q2 mo<br>1:00 pm<br>Dr. Glover 591-5443                            |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>CARDIOLOGY</b><br>2nd Mon q3 mo<br>9:00 am<br>Dr. Singh 591-7770                           |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>GYNECOLOGY</b><br>3rd Mon q3 mo<br>9:30 am<br>Dr. Leary 281-5000                           |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>DERMATOLOGY</b><br>3rd Thurs q3 mos<br>9:30 am<br>Dr. Silverman 641-0083                   |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>ALLERGY</b><br>3rd Thurs q3 mo<br>9:30 am<br>Dr. Schuster 689-2000                         |     |     |     |     |     |     |     |     |     |     |     |     |
| <b>GENETIC</b><br>Joer<br>Joerbaum (202)8842187                                               |     |     |     |     |     |     |     |     |     |     |     |     |
|                                                                                               |     |     |     |     |     |     |     |     |     |     |     |     |
|                                                                                               |     |     |     |     |     |     |     |     |     |     |     |     |
|                                                                                               |     |     |     |     |     |     |     |     |     |     |     |     |

**RESIDENTIAL/CLINICAL SERVICES PRIORITIZED EQUIPMENT LIST**  
**FROM FY '93 - '94 RETURN YEAR END MONEY**  
**February 24, 1995**

18

| Equipment Description<br>By Priority | Requester        | Qty | Unit Price | Price      | Available Balance | ORDERED | RC'd |
|--------------------------------------|------------------|-----|------------|------------|-------------------|---------|------|
|                                      |                  |     |            |            | \$113,000.00      |         |      |
| <b>PHYSICAL THERAPY</b>              |                  |     |            |            |                   |         |      |
| Puritan-Bennett Percussor            | P.T. (Unit 1)    | 1   | \$450.00   | \$450.00   | \$112,550.00      | X       |      |
| Positioning Chairs for Mealtime      | P.T. - (Bldg. 3) | 30  | \$177.30   | \$5,319.00 | \$107,231.00      | X       | X    |
|                                      |                  |     |            |            |                   |         |      |
| <b>OCCUPATIONAL THERAPY</b>          |                  |     |            |            |                   |         |      |
| Sensory Integration                  | O.T.             | 1   | \$2,041.02 | \$2,041.02 | \$105,189.98      | X       |      |
| T.V. Monitor                         | O.T.             | 1   | \$369.96   | \$369.96   | \$104,820.02      | X       |      |
| VCR - video-fluoroscopies            | O.T.             | 1   | \$525.00   | \$525.00   | \$104,295.02      | X       | X    |
| Cart (f/monitor & VCR)               | O.T.             | 1   | \$109.00   | \$109.00   | \$104,186.02      | X       | X    |
| Portable Forma-Splinting Pan         | O.T.             | 1   | \$594.00   | \$594.00   | \$103,592.02      | X       |      |
| <b>SPEECH &amp; HEARING</b>          |                  |     |            |            |                   |         |      |
| Board Maker                          | Speech           | 1   | \$399.00   | \$399.00   | \$103,193.02      | X       | X    |
| Board Maker Supplies                 | Speech           | 1   | \$350.00   | \$350.00   | \$102,843.02      | X       | X    |
| Color Ink Jet Printer                | Speech           | 1   | \$315.00   | \$315.00   | \$102,528.02      | X       | X    |
|                                      |                  |     |            |            |                   |         |      |
|                                      |                  |     |            |            |                   |         |      |

| Equipment List<br>By PRISER                                                        | Requestor  | Qty | Unit Price | Price      | Available<br>Balance | Ordered | Rec'd |
|------------------------------------------------------------------------------------|------------|-----|------------|------------|----------------------|---------|-------|
| <b>AUGMENTATIVE DEVICES<br/>LISTED BELOW</b>                                       |            |     |            |            |                      |         |       |
| Speak Easy AlbeNet<br>w/keyguard                                                   | Speech     | 3   | \$383.00   | \$1,149.00 | \$101,379.02         | X       | X     |
| Hawk AdamLab                                                                       | Speech     | 2   | \$175.00   | \$350.00   | \$101,029.02         | X       | X     |
| Cybersmith's VRA<br>System VI-Deluxe<br>Bioacoustics, Inc                          | Audiology  | 1   | \$1,200.00 | \$1,200.00 | \$99,829.02          | X       |       |
| DynaVox Augmentative<br>Advice                                                     | Speech     | 1   | \$4,525.00 | \$4,525.00 | \$95,304.02          | X       | X     |
| Walker-Talker Prentke-<br>Romich                                                   | Speech     | 1   | \$1,543.00 | \$1,543.00 | \$93,761.02          | X       | X     |
| Alpha Talker with<br>Headset + 4 & 8 location<br>operating kits Prentke-<br>Romich | Speech     | 1   | \$1,495.00 | \$1,495.00 | \$92,266.02          | X       | X     |
| Shelving for<br>Augmentative/<br>Assistive Library                                 | Speech     | 1   | \$1,067.00 | \$1,067.00 | \$91,199.02          | X       |       |
| <b>RECREATION</b>                                                                  |            |     |            |            |                      |         |       |
| Basketball Rim/Hoop                                                                | Recreation | 1   | \$700.00   | \$700.00   | \$90,499.02          | X       |       |
| Tent (large 2 rms.)                                                                | Recreation | 1   | \$299.00   | \$299.00   | \$90,200.02          | X       |       |
| Tent (small)                                                                       | Recreation | 1   | \$70.00    | \$70.00    | \$90,130.02          | X       | X     |
| Roller Skates                                                                      | Recreation | 8   | \$40.00    | \$320.00   | \$89,810.02          | X       | X     |
| Sleeping Bags                                                                      | Recreation | 8   | \$28.00    | \$224.00   | \$89,586.02          | X       |       |
| Padded Folding Chairs                                                              | Recreation | 32  | \$12.60    | \$403.20   | \$89,182.82          | X       | X     |
| Upr' Chair Rack                                                                    | Recreation | 1   | \$283.00   | \$283.00   | \$88,899.82          | X       | X     |

| Equipment List<br>By Priority              | Reference                            | Qty | Unit Price  | Price       | Available Balance | Ordered | Re'd |
|--------------------------------------------|--------------------------------------|-----|-------------|-------------|-------------------|---------|------|
| <b>PSYCHOLOGY</b>                          |                                      |     |             |             |                   |         |      |
| Video Camera<br>(w/accessories )           | Psychology                           | 1   | \$1,117.50  | \$1,117.50  | \$87,782.32       | X       | X    |
| VCR                                        | Psychology                           | 1   | \$525.00    | \$525.00    | \$87,257.32       | X       | X    |
| Cart (f/monitor &<br>VCR)                  | Psychology                           | 1   | \$109.23    | \$109.23    | \$87,148.09       | X       | X    |
| Stat/Graphic Computer<br>Software Pkg.     | Psychology                           | 1   | \$800.00    | \$800.00    | \$86,348.09       |         |      |
| Desk                                       | Psy(2)                               | 2   | \$253.00    | \$506.00    | \$85,842.09       | X       |      |
| TV Monitor                                 | Psychology                           | 1   | \$369.96    | \$369.96    | \$85,472.13       | X       |      |
| <b>RESIDENTIAL SERVICES</b>                |                                      |     |             | \$0.00      | \$85,472.13       |         |      |
| <b>EQUIPMENT/SERVICES</b>                  |                                      |     |             | \$0.00      | \$85,472.13       |         |      |
| Nutritional Consultant<br>Management Team  |                                      | 1   | \$15,000.00 | \$15,000.00 | \$70,472.13       | X       |      |
| Mats for Quiet Rooms<br>(Closed cell foam) | Bldg. 5, 6, 7, 8<br>all quiet rooms  | 12  | \$170.60    | \$2,047.20  | \$68,424.93       | X       |      |
| Desk                                       | Bldg. 3(10,<br>Bldg. 5(1)            | 2   | \$253.00    | \$506.00    | \$67,918.93       | X       |      |
| Computer Tables                            | Bldg. 3(1),<br>5(3), 6 (2), 7<br>(1) | 7   | \$150.00    | \$1,050.00  | \$66,868.93       | X       |      |
| Printers - Ink                             | Bldg. 3(1),<br>5(20, 7(1),<br>891)   | 5   | \$256.41    | \$1,282.05  | \$65,586.88       | X       | X    |
| Printers - Laser                           | Bldg. 6(10,<br>7(10, 891)            | 3   | \$500.00    | \$1,500.00  | \$64,086.88       |         |      |
| Medication Carts                           | Bldgs. 1, 3, 5,<br>6, 7, 8,          | 11  | \$1,000.00  | \$11,000.00 | \$53,086.88       |         |      |

| Equipment List<br>By Priority | Request For                                                         | Qty | Unit Price | Price       | Available<br>Balance | Ordered | RC 6 |
|-------------------------------|---------------------------------------------------------------------|-----|------------|-------------|----------------------|---------|------|
| <b>FURNITURE</b>              |                                                                     |     |            |             |                      |         |      |
| Table (End)                   | Bldg. 6                                                             | 10  | \$284.50   | \$2,845.00  | \$50,241.88          | X       |      |
| Television (20")              | Bldg. - 6(2),<br>7(1),                                              | 1   | \$210.00   | \$210.00    | \$50,031.88          | X       | X    |
| Television (24' Console)      | Bldg. 3 91)                                                         | 1   | \$330.00   | \$330.00    | \$49,701.88          | X       | X    |
| Entertainment Cabinets        | Bldg. - 3(6),<br>5(3), 6(3),<br>7(4), 8(4)                          | 21  | \$800.00   | \$16,800.00 | \$32,901.88          |         |      |
| Chairs (Office &<br>Recliner  | *Unit 1(2<br>Recliners)<br>Bldg. 6<br>(4roller/4 arm)<br>***hold*** | 4   | \$479.50   | \$1,918.00  | \$30,983.88          |         |      |
| <b>HOME FURNISHING</b>        | \$30,983.88                                                         |     |            |             |                      |         |      |
|                               |                                                                     |     |            |             |                      |         |      |
| Unit 1 Ambience               |                                                                     | 1   | \$1,000.00 | \$1,000.00  | \$29,983.88          | X       | X    |
| Bldg. 3 Ambience              |                                                                     | 1   | \$3,000.00 | \$3,000.00  | \$26,983.88          | X       | X    |
| Bldg. 5 Ambience              |                                                                     | 1   | \$3,000.00 | \$3,000.00  | \$23,983.88          | X       | X    |
| Bldg. 6 Ambience              |                                                                     | 1   | \$2,000.00 | \$2,000.00  | \$21,983.88          | X       | X    |
| Bldg. 7 Ambience              |                                                                     | 1   | \$1,000.00 | \$1,000.00  | \$20,983.88          | X       | X    |
| Bldg. 8 Ambience              |                                                                     | 1   | \$1,000.00 | \$1,000.00  | \$19,983.88          | X       | X    |
|                               |                                                                     |     |            | \$0.00      | \$19,983.88          |         |      |
|                               |                                                                     |     |            | \$0.00      | \$19,983.88          |         |      |

## QUALITY ASSURANCE PROGRAM FOR HEALTH SERVICES

**POLICY:** Health Services shall maintain a quality assurance program to provide a structured mechanism whereby the qualifications of staff can be assured, performance of staff and of programs can be characterized, and certain features of services, such as, prescribing practices and outcome variables, can be measured and compared to standards of practice in our community and in the MR field nationally. A peer review component shall be included. The program shall operate through the Medical Director's Office; shall involve several of the committees of the Department, and shall be coordinated with and an integral part of the overall NVTC QA program.

**PROCEDURES:****CREDENTIALING:**

1. Under the supervision of the Medical Director and with written consent of the applicant, the Administrative Secretary obtains direct written verification of medical school graduation, postgraduate medical education, medical licensure, board certification, liability insurance coverage, and hospital affiliations of staff physicians and consultants.
2. Analogous information is obtained regarding other professional staff members of the department.
3. In addition to the above, current copies of the physician's Federal DEA Registration, State Controlled Substance Registration, state license, and title page of malpractice policy are kept on file in the Medical Director's Office.

**STAFF EDUCATION:**

1. Each staff member will be encouraged to attain board certification and/or qualification by nationally recognized accrediting bodies pertaining to competency in their particular discipline.
2. Staff will be encouraged to become members of professional organizations relevant to developmental disabilities and to attend as many pertinent educational courses as time and resources permit.
3. The Department will sponsor regular educational events, such as, journal clubs, grand rounds, guest lecturers, and other didactic events to specifically focus on timely topics of assessment and management.

**COMMITTEE PARTICIPATION:**

1. The Clinical Practice Review Committee will convene promptly after an adverse event or outcome to review the findings of the Director of Quality Assurance and of the Medical Director regarding



the case and/or event and to devise changes in practice, procedures, or systems of care brought to light by the inquiry; results will be reported to the Facility Director.

2. The Pharmacy and Therapeutics Committee and the Infection Control Committee will regularly evaluate prescribing practices and other aspects of care within their respective domains; results will be reported to the Director of Quality Assurance, the Medical Director, and the Facility Director.

3. Various committees of the Health Task Force, for example, the Dysphagia Committee and the Epilepsy Committee, may, from time to time, evaluate various parameters of care and clinical outcomes within their respective domains; results will be reported to the Director of Quality Assurance, the Medical Director, and the Facility Director.

#### PEER REVIEW:

1. Physician peer review will be conducted quarterly under the professional guidance of the Director of Medical Records.

2. The Medical Director and the Director of Medical Records will devise and revise chart review criteria for each review session, depending upon the stage of evolution of the NVTC plan for medical records improvement.

3. The Director of Medical Records will utilize standard professional criteria to select charts to be reviewed.

4. The peer review physicians will consist of the Medical Director and a visiting, board certified, primary care physician with experience in residential care of people with developmental disabilities; the Medical Director will not review charts of clients whom he has served as the primary physician.

5. At the conclusion of the peer review session, a briefing will be conducted by the reviewers for the Director of Medical Records, the Director of Quality Assurance, and the members of the medical and nurse practitioner staff; a report will be written by the Director of Medical Records for the Director of Quality Assurance, the Medical Director, and the Facility Director.

6. Annually, Columbus Medical Services will conduct a comprehensive peer review of records utilizing a physician-nurse team in concert with on-site staff; a report will be submitted by Columbus Medical Services to the Facility Director.

NEUROLOGY CLINIC-ANTICONVULSANT MEDICATION REVIEW

NAME \_\_\_\_\_ DATE \_\_\_\_\_ UNIT \_\_\_\_\_

LAST CLINIC VISIT \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_ WEIGHT \_\_\_\_\_ PROBLEM NO. \_\_\_\_\_

TYPE OF VISIT: \_\_\_\_\_ MEDICATION CHANGES: \_\_\_\_\_ ANNUAL REVIEW: \_\_\_\_\_

CURRENT AED \_\_\_\_\_ TOTAL DAILY DOSE \_\_\_\_\_

CHANGES IN AED SINCE LAST REVIEW AND DATE

LABORATORY RESULTS:

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

WBC \_\_\_\_\_

SGOT \_\_\_\_\_

DILANTIN \_\_\_\_\_

HGB \_\_\_\_\_

SGPT \_\_\_\_\_

TEGRETOL \_\_\_\_\_

HCT \_\_\_\_\_

SER NA \_\_\_\_\_

DEPAKOTE \_\_\_\_\_

PL CT \_\_\_\_\_

NH3 \_\_\_\_\_

PHENOBARITAL \_\_\_\_\_

GGT \_\_\_\_\_

MYSOLINE \_\_\_\_\_

GABAPENTIN \_\_\_\_\_

LAMOTRIGINE \_\_\_\_\_

FE OF LAST RECORDED SEIZURE \_\_\_\_\_

PHYSICIAN RECOMMENDATIONS:

# NVTC SEIZURE RECORD: FORM #141

## Guidelines for Use of Form

---

**PURPOSE:** To document the number of seizure episodes that have occurred during a designated period of time.

1. The form is started on the first of each month. The month and year are written on the lower left corner of the form. If no seizures have occurred during the month, "0" is written after the month and the form is used repeatedly until seizure activity occurs.

2. Mark an "X" in the column for the appropriate shift with the correct time. An "X" with the time is written for seizure episode.

3. The description of the seizure is documented on the back of the form to indicate what the observer has witnessed instead of classifying the seizure.

4. Form #141 are located in a red book on each of the individual client units.

## 41

It may not be used.

January \_\_\_\_\_ April \_\_\_\_\_ July \_\_\_\_\_ October \_\_\_\_\_

or Previous Year 19\_\_\_\_ February\_\_\_\_ May\_\_\_\_ August\_\_\_\_ November\_\_\_\_

March \_\_\_\_\_ June \_\_\_\_\_ September \_\_\_\_\_ December \_\_\_\_\_

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.

Date of Last Seizure \_\_\_\_\_

## INSTRUCTIONS

1. Start form on the first of the month, and write month on lower left. If no seizures occur during the month, write "0" after the month and use the same page for the next month (add month name to next blank line on sheet)

Example: January - 0  
February - 0  
March - 6

2. Mark X in correct time and date box on left.
3. For seizures in cluster circle the (X).
4. Document seizure with description on back of this form.
5. In January of each year, summarize number of seizures for previous year at the top of this form.

th(s) \_\_\_\_\_ Year \_\_\_\_\_

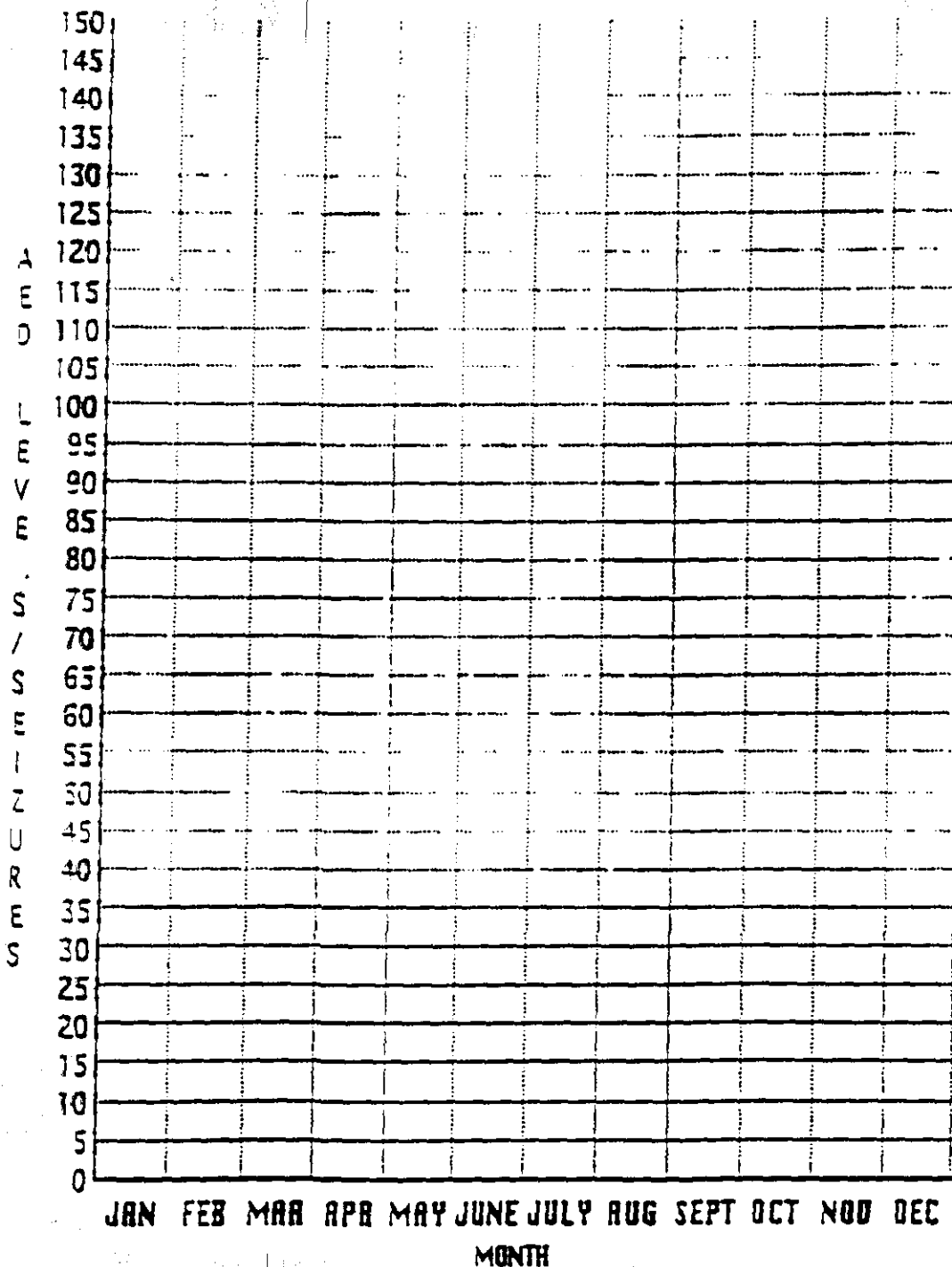
Year \_\_\_\_\_



nt Name: \_\_\_\_\_

Year Under Review: \_\_\_\_\_

RED LEVELS: SEIZURES 19\_\_



- ☐ SEIZURES
- ☐ DEPAKENE
- ☐ TEGRETOL
- ☐ MYSOLINE
- ☐ PHENOBARR
- ☐ DILANTIN
- ☐ GABAPENTIN
- ☐ LAMOTRIGINE

Additional Data: \_\_\_\_\_

# SEIZURE TOTALS

| <u>Month</u> | 1992  | 1993  | 1994  | 1995  | 1996  | 1997  |
|--------------|-------|-------|-------|-------|-------|-------|
| <u>Jan</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Feb</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Mar</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Apr</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>May</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Jun</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Jul</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Aug</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Sep</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Oct</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Nov</u>   | _____ | _____ | _____ | _____ | _____ | _____ |
| <u>Dec</u>   | _____ | _____ | _____ | _____ | _____ | _____ |

Addressograph

## EPILEPSY MANAGEMENT

---

**PURPOSE:** To provide guidelines for epilepsy management.

**PROCEDURE:** The following procedures are followed for clients at NVTC with a diagnosis of epilepsy:

1. Seizure nursing care plans are monitored at least monthly by a registered nurse.
2. Each client has an individualized nursing care plan that addresses:
  - following the physician's orders regarding medications, protective devices and anti-epileptic drug levels.
  - accurate documentation of any seizure activity on NVTC Form #141 (see attached form).
3. Provide first aid precautions or proper care during seizure activity:
  - place something soft under the head
  - clear the area of sharp or hard objects
  - do not force any object onto the mouth
  - do not restrain the client's movements
  - turn the client on side when able to allow saliva to drain from the mouth
  - stay with the client until the seizure naturally ends
  - do not pour any liquids into the client's mouth or offer any food, drink or medication until fully awake
  - give artificial respiration if the client does not resume breathing after the seizure.
4. Each client's individualized seizure care plan, located on the unit in a red book, describes the usual, typical seizure pattern and duration. Any changes, unusual occurrences, or if the seizure activity is prolonged and another one starts soon after first, call the infirmary at extension 4028 or 4029.
5. The registered nurse assesses seizure activity by evaluating:
  - the type of seizure
  - if the number and character are unusual for the client, check for temperature elevation and constipation
  - respiratory status.



6. If the client is diabetic, evaluate the following:

- any presence of injury
- check that labs are within therapeutic levels
- any evidence of missed medications
- check for any standing recommendations for status episodes.

7. The registered nurse will provide the following measures:

- a safe environment and position on side to keep airway open if unconscious
- remove glasses
- do not restrain movements or put anything in the mouth
- perform a rectal examination and temperature check if an unusual number of seizures
- allow to sleep/rest until fully alert
- bring to the infirmary if in status or if the character is unusual and persists
- call 911 if does not wake up after seizure or does not breathe
- if the client is not breathing, begin respiratory management and call 911.

8. The registered nurse will notify the physician if:

- there is no history of seizure episodes
- unusual character or excessive number of seizures
- any injury related to seizure episodes
- the client is in status epilepticus
- need to obtain physician's order to initiate medical treatment for status epilepticus
- there is a need to transport the client to the infirmary
- a need for physician's order regarding first aid, medications or protective appliances.

#### References:

- Client's individualized GOP for epilepsy management.
- Nurses' pocket guidelines for seizure management.

NURSING DIAGNOSIS: Potential for Injury Due to Seizures.

|                      |      |                                            |
|----------------------|------|--------------------------------------------|
| Problem/<br>Need No. | Date | Goals:                                     |
|                      |      | To prevent injury during seizure activity. |

Relevant Strengths:

| Problem/Need/<br>Objective<br>No. | Date | OBJECTIVES                                           | Date<br>Met |
|-----------------------------------|------|------------------------------------------------------|-------------|
|                                   |      | To have _____ incidences of seizure-related injuries |             |
|                                   |      | through _____.                                       |             |
|                                   |      |                                                      |             |
|                                   |      |                                                      |             |
|                                   |      |                                                      |             |
|                                   |      |                                                      |             |
|                                   |      |                                                      |             |
|                                   |      |                                                      |             |

Nursing Care PLANS Direct Care Staff Will:

|   |                                                         |
|---|---------------------------------------------------------|
| 1 | Follow physician's orders.                              |
| 2 | Keep accurate documentation of seizure activity.        |
| 3 | Give proper care during seizure (see reverse side).     |
| 4 | Encourage additional fluids between meals.              |
| 5 | Report any changes in seizure pattern to MD or RN.      |
| 6 | Report to MD or RN any seizure lasting more than _____. |
| 7 | Observe for pre-seizure activity _____.                 |
|   |                                                         |
|   |                                                         |
|   |                                                         |
|   | Monitor monthly by RN.                                  |
|   |                                                         |
|   |                                                         |

Dept. of Mental Health, Mental Retardation,  
and Substance Abuse Services

Facility \_\_\_\_\_ NVTC

ADDRESSOGRAPH

GOALS, OBJECTIVES, AND PLANS

1. Justification for changes must be documented on the I D Notes.
2. Objectives must include target dates.

Date and discipline

### SPLINTERS

| ASSESSMENT                                                                                                                                                                                                                                                                                                                                       | IMMEDIATE RX                                                                                                                                                                                                                                                                                                                                                                                | NOTIFY M.D. IF:                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>- increased erythema/skin color</li> <li>- increased swelling</li> <li>- splinter visibility</li> <li>- bleeding</li> <li>- soreness/pain</li> <li>- origin of F/B</li> <li>- type of splinter (wood, metal, etc.)</li> <li>- elevated T</li> <li>- allergies</li> <li>- immunizations current</li> </ul> | <ul style="list-style-type: none"> <li>- Using gloves</li> <li>- clean area with soap and water. If splinter is wood, clean but do not soak.</li> <li>- gently remove with clean tweezers. sterilized needle</li> <li>- wash again after splinter is removed</li> <li>- apply 1X Betadine/Bacuracin</li> <li>- sterile dressing (if needed)</li> <li>- Tylenol XI for discomfort</li> </ul> | <ul style="list-style-type: none"> <li>- splinter can't be removed</li> <li>- area appears infected</li> <li>- need for further pain medication</li> </ul> |

### POCKET GUIDELINES

#### SEIZURES

| ASSESSMENT                                                                                                                                                                                                                                                                                                                                                                         | IMMEDIATE RX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | NOTIFY M.D. IF:                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>- type of seizure</li> <li>- if number and character are unusual for client, check for temp elevation and constipation</li> <li>- respiratory status</li> <li>- is the client diabetic?</li> <li>- injury</li> <li>- labs (within therapeutic levels)</li> <li>- missed medications</li> <li>- standing order for status episode</li> </ul> | <ul style="list-style-type: none"> <li>- provide safe environment and position on side to keep airway open if unconscious</li> <li>- remove glasses</li> <li>- do not restrain movements or put anything in mouth</li> <li>- digital (rectal exam) and temp check if unusual number of seizures</li> <li>- allow to sleep/rest until fully alert</li> <li>- bring to infirmary if in status or if number and character are unusual and persist</li> <li>- call 911 if does not wake up after seizure or does not breathe</li> <li>- if does not breathe, begin respiratory management and call 911</li> </ul> | <ul style="list-style-type: none"> <li>- status</li> <li>- 911 called</li> <li>- seizure-related injury</li> <li>- no history of seizures</li> <li>- unusual character or excessive number</li> <li>- constipated — order for supp/enema</li> <li>- S.O. medication is administered</li> </ul> |

# FIRST AID FOR SEIZURES

First aid for epilepsy is basically very simple, and is designed to protect the safety of the person until the seizure stops naturally by itself. If you see someone having a seizure, stay calm and follow these simple rules:

---

- PROTECT FROM NEARBY HAZARDS
  - LOOSEN TIES OR SHIRT COLLARS
  - PLACE SOFT MATERIAL UNDER THE HEAD
  - DONT RESTRAIN
  - DONT PUT ANY HARD IMPLEMENT IN MOUTH
  - DONT TRY TO HOLD TONGUE - IT CANT BE SWALLOWED
  - DONT TRY TO GIVE LIQUIDS DURING OR JUST AFTER SEIZURE
  - TURN ON SIDE TO KEEP AIRWAY CLEAR
  - REASSURE WHEN CONSCIOUSNESS RETURNS
  - DONT USE ARTIFICIAL RESPIRATION UNLESS BREATHING IS ABSENT AFTER MUSCLE JERKS SUBSIDE, OR UNLESS WATER HAS BEEN INHALED
  - IF SEIZURE IS PROLONGED OR ANOTHER ONE STARTS SOON AFTER THE FIRST, CALL THE INFIRMARY AT X-4028/4029.
-

## EMERGENCY MEDICAL DRILLS

---

**PURPOSE:** To establish a system for staff to review and/or practice appropriate responses to medical emergencies. Through mock emergency situations which simulate those most likely to occur in a particular work site, nursing and paraprofessional staff will be able to practice skills and agency procedures in medical emergencies.

**TARGET STAFF:** The primary staff required to participate in emergency drills will be unit nurses, CTR and infirmery staff, and unit direct care staff.

**RESPONSIBILITY:** The following staff will have designated responsibilities in ensuring that staff have adequate information and opportunity to practice and understand their role in a medical emergency on a monthly basis:

- Nurse Manager - communicate the requirements to the appropriate nurses; develop specific emergency situations/scenarios generic to different work sites; schedule BLS classes for nurses.

- Unit Nurses - coordinate scheduling of drills; select appropriate scenarios; process with participants afterwards.

- Direct Care Staff/Supervisors - participate in needed training for appropriate emergency medical care; participate in drills in preparation for real situations; process afterwards.

- Training Department - provide on-going CPR classes to direct care staff; assist in drills and processing as requested by unit nurses; document participation in individualized computerized training records.

**PROCEDURE:** See attached Emergency Medical Drills Procedure.

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## EMERGENCY MEDICAL DRILLS PROCEDURE

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1. Unit nurses will prepare a scenario.
2. A date and time will be set by the unit nurse and shift developmental technician.
3. Unit nurse will notify all participants on Center grounds that a "mock drill" has been scheduled and give the date and time.
4. Unit staff discover victim and begin emergency procedures.
5. One staff remains with victim, one staff initiates calls to infirmary and switchboard.
6. Infirmary nurse receives call from the unit and responds.
7. Infirmary nurse makes assessment then directs unit staff to call 911.
8. Infirmary nurse/unit staff continue with rescue breathing/CPR until EMS arrives.
9. Infirmary nurse gives EMS report, prepares emergency transfer papers, calls unit physician, hospital, parents and facility director.
10. Unit nurse records sequence of events and time. Also critiques the emergency medical response drill. The drill report is forwarded to the director of nursing.

### FREQUENCY OF DRILLS

|           |     |         |
|-----------|-----|---------|
| January   | ... | Unit 1  |
| February  | ... | Unit 3A |
| March     | ... | Unit 3C |
| April     | ... | Unit 3D |
| May       | ... | STC     |
| June      | ... | Unit 5A |
| July      | ... | Unit 5C |
| August    | ... | Unit 6A |
| September | ... | Unit 7A |
| October   | ... | Unit 7C |
| November  | ... | Unit 8A |
| December  | ... | Unit 8C |

Drills Procedure  
Page 2

The drill procedure is an adjunct to NVTC Instruction 5600: Medical Emergency Procedures.

The basic steps for medical emergency procedures have been outlined, laminated, and placed by all telephones on the residential units and the Skills Training Center (STC).

**DOCUMENTATION:** The three-page form titled "Medical Emergency Response Drill," along with an attendance sheet, will be forwarded to the training department and the nurse manager. (Form is attached.)

**EVALUATION:** The nurse coordinating the mock review will critique the drill with chronological events, and sends the original copy to the nurse manager. The nurse manager reviews the medical emergency response drill and makes referrals to appropriate personnel as necessary.

## MEDICAL EMERGENCY RESPONSE DRILL

DATE:

UNIT:

### PARTICIPANTS:

1. VICTIM
  2. UNIT STAFF
  3. \*UNIT NURSE (RECORDER, CRITIQUE)
  4. \*INFIRMARY NURSE (ASSESSES VICTIM, DIRECTS SEQUENCE OF EVENTS, PREPARES EML PAPERS, CALLS MD, HOSPITAL, PARENTS, FACILITY DIRECTOR)
  5. TELEPHONE OPERATOR (NOTIFIES SECURITY AND RTL)
  6. EMT (SIMULATED)
  7. UNIT PHYSICIAN
  8. SECURITY
  9. ROVING TEAM LEADER (4PM-8AM)
  10. HOSPITAL, PARENTS, FACILITY DIRECTOR
- \*ROLES WILL ALSO BE REVERSED

### SCENARIO:

### TIME AND SEQUENCE OF EVENTS



**EMERGENCY MEDICAL RESPONSE DRILL**

**PAGE 2**

**DATE:**

**UNIT:**

**TIME AND SEQUENCE OF EVENTS(CONTINUED)**

**CRITIQUE:**

A 1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12

**MEDICAL EMERGENCY RESPONSE DRILL**  
PAGE 3

PROCEDURE:

1. UNIT NURSE WILL PREPARE A SCENARIO
2. A DATE AND TIME WILL BE SET BY UNIT NURSE AND SHIFT TECH.
3. UNIT NURSE WILL NOTIFY ALL PARTICIPANTS ON CENTER GROUNDS A "MOCK" DRILL HAD BEEN SCHEDULED, DATE AND TIME.
4. UNIT STAFF FIND VICTIM AND BEGIN EMERGENCY PROCEDURES.
5. ONE STAFF REMAINS WITH VICTIM. ONE STAFF INITIATES CALLS TO INFIRMARY AND SWITCHBOARD.
6. INFIRMARY NURSE RECEIVES CALL FROM UNIT AND RESPONDS.
7. INFIRMARY NURSE MAKES ASSESSMENT THEN DIRECTS CARE, DIRECTS UNIT STAFF TO CALL 911.
8. INFIRMARY NURSE/UNIT STAFF CONTINUE WITH RESCUE BREATHING/CPR UNTIL EMT ARRIVES.
9. INFIRMARY NURSE GIVES EMT REPORT, PREPARES EMERGENCY TRANSFER PAPERS, CALLS UNIT PHYSICIAN/ON CALL PHYSICIAN, HOSPITAL, PARENTS, DR. LAWSON.
10. UNIT NURSE RECORDS SEQUENCE OF EVENTS AND TIMES AND DOES CRITIQUE.

THE ROLE OF THE UNIT NURSE AND INFIRMARY WILL BE REVERSED ON OCCASION.

SCHEDULE:

|            |         |
|------------|---------|
| JANUARY:   | UNIT 1  |
| FEBRUARY:  | UNIT 2A |
| MARCH:     | UNIT 3C |
| APRIL:     | UNIT 3D |
| MAY:       | STC     |
| JUNE:      | UNIT 5A |
| JULY:      | UNIT 5C |
| AUGUST:    | UNIT 6A |
| SEPTEMBER: | UNIT 7A |
| OCTOBER:   | UNIT 7C |
| NOVEMBER:  | UNIT 8A |
| DECEMBER:  | UNIT 8C |

RESPONSE FORMS TO BE COMPLETED AND TURNED IN TO DEBORAH COOK, R.N. WITHIN 3 DAYS.

## 911 EMS LOG PROCEDURE

---

**PURPOSE:** To have an accurate record of the response time of the rescue squad and nurse in implementing the emergency medical system (EMS) 911 calls.

### **PROCEDURE:**

1. The nurse answering the telephone in the infirmary is responsible for recording the following information:
  - a) time of the call from the unit
  - b) nature of the emergency
  - c) time the nurse is dispatched to the unit
  - d) arrival time of the nurse to the unit
  - e) arrival time of EMT to the unit.
2. The infirmary nurse may delegate the steps above to a unit nurse if the telephone calls were made by the nurse/staff directly from the unit.
3. The unit nurse is responsible for providing the infirmary with the information in steps a, b, c, d and e if she/he was on the unit or responded to the emergency.
4. The nurse recording the information should be precise in noting the response time of the nurse and rescue squad.
5. The log is reviewed daily by the charge nurse in the infirmary.
6. The recording of the information is monitored by the infirmary supervisor for completeness.
7. The information is forwarded to the risk manager on a quarterly basis.



## MEDICAL EMERGENCY PROCEDURES

---

**FOLLOW THESE PROCEDURES IN LIFE THREATENING EMERGENCIES (UNCONSCIOUS, NOT BREATHING AND/OR CARDIO-PULMONARY ARREST):**

- 1) **Begin rescue breathing or CPR *immediately*.**
- 2) **Instruct available staff to call 911. The caller will:**
  - ~ dial 911 and ask for an emergency rescue squad for NVTC, 9901 Braddock Road, Fairfax, VA. Give building number. He/She will indicate the telephone number that he/she is calling from, what happened, how many persons need help, what is being done for the victim(s). Allow the emergency personnel to hang up first; caller should hang up last.**
- 3) **Telephone the infirmary (ext. 4028/4029) to notify them of the emergency.**
- 4) **Keep the telephone line clear to receive incoming calls from the emergency rescue service personnel.**

(These procedures are posted on all residential units)

NORTHERN VIRGINIA TRAINING CENTER

Fairfax, Virginia

ATTACHMENT

25

February 1, 1994

NVTC INSTRUCTION 5600

TO: Staff

SUBJECT: *Medical Emergency Procedures*

- I. Purpose. To disseminate information concerning management of medical emergencies on and off campus.
- II. Cancellation. NVTC Instruction 5600 dated August 16, 1993 is hereby canceled.
- III. Procedure.
  - A. Life Threatening Emergency (Unconscious, Not Breathing and/or Cardio—Pulmonary Arrest):
    1. A certified CPR technician located on the unit/ department will be notified immediately.
      - a. begin rescue breathing or CPR immediately,
      - b. instruct available staff to call 911.
    2. The caller will:
      - a. Dial 911 and ask for Emergency Rescue Squad Service at NVTC, 9901 Braddock Road, Fairfax, Virginia. Building # \_\_\_\_ He/she will indicate the telephone number that he/she is calling from, what happened, how many persons need help, and what is being done for the victim(s). Allow the Emergency personnel to hang up first. Caller should hang up last.
      - b. Next, phone the Infirmary/ Central Treatment Room (duty hours) or the Infirmary (non-duty hours) to notify them of the emergency.
      - c. Then keep the phone line clear to receive incoming calls, from the Emergency Rescue Service personnel.
    3. The Central Treatment Room/Infirmary shall:
      - a. Notify the attending/ on-call physician in order to dispatch him/her to the emergency location.
      - b. Dispatch a nurse to the emergency location.
      - c. Notify the Director's office (duty hours) or the Staff Duty Officer/ Roving Team Leader (non-duty hours). It may be necessary to do this through the switchboard.

emergency has been evaluated, unless the parents/guardians have been called by the hospital emergency room physician.

4. When the client returns to NVTC, he/she shall be brought to the CTR during work hours or to the infirmary at other times. The client shall be evaluated by a nurse and if additional treatment by the attending or on-call physician is warranted, the physician shall be notified.
- D. The following documents and information should accompany the client to the hospital when possible:
1. Consent for Medical/Surgical Treatment (copies available in the Infirmary).
  2. New Admission Medical Summary, Physician's Medical Summary, Laboratory results, X-ray films (if done at NVTC), and Nursing Transfer Summary.
  3. Current Medication Order, Physician's Orders, diet and allergies, contagious disease information, and pertinent behavioral problems.
  4. Insurance information.
  5. Name and address of parents/guardians.
  6. Name of the attending physician and/or physician on call.
  7. Name of consultant if known.
- E. When the medical emergency is poison related, the Poison Control Center at Georgetown University Hospital will be called by the CTR or Infirmary nurse. The attending or on-call physician is then contacted by the nurse and informed of the circumstances and will provide additional instructions to that given by the Poison Control Center. The telephone number of the Poison Control Center will be posted in the Central Treatment Room and the Infirmary.
- F. The telephone numbers of the rescue squad and emergency rooms of the nearby hospital shall be posted at telephone sites in the CTR and Infirmary.

IV. Effective Date. This Instruction will become effective on the date issued.



David H. Lawson, Ph.D.  
Director

# CHANGES IN PSYCHOTROPIC MEDICATION PRESCRIBING PATTERNS

1989 - 1995

|                                 | Mid '89      | 10/93        | 2/95         |
|---------------------------------|--------------|--------------|--------------|
| PSYCHOTROPIC                    | 58/278 (21%) | 39/253 (15%) | 35/236 (15%) |
| DRUG CATEGORIES                 |              |              |              |
| Antipsychotics                  | 39           | 33           | 26*          |
| Lithium                         | 2            | 4            | 3            |
| Antidepressants                 | 6            | 5            | 11           |
| Anti-anxiety/<br>Sedative drugs | 5            | 0            | 1            |
| Antiepileptic drugs             | 6            | 0            | 0            |
| (Cootherapy)                    | -7           | -3           | -6           |

\* This represents a one-third reduction of antipsychotic (neuroleptic) drugs over a nearly 5 year period.

Michael B. Kurtz, M.D.  
Medical Director  
2/28/95



NVTC  
HEALTH SERVICES  
STANDING ORDER NO. 28 (Rev 8/93)

-----

**TARDIVE DYSKINESIA**

**POLICY:** Clients receiving anti-psychotic medications will be evaluated at least quarterly by nurses who have received special training and at least annually by primary physicians and nurse practitioners at the time of the annual physical evaluation. If signs and symptoms suggesting tardive dyskinesia are detected, clients will be referred for further evaluation and treatment.

**PROCEDURE:**

1. Nurses will screen all clients receiving anti-psychotic medications on a quarterly basis, as set forth in Nursing Policy #28.
2. Physicians and nurse practitioners performing annual physical examinations on clients receiving psychotropic medications will observe involuntary movements, postural and muscular tone changes and document them on NVTC Form 99.
3. Persons suspected of tardive dyskinesia will be referred for further psychiatric and/or neurologic consultation to confirm or refute the suspected diagnosis and to rule in or out alternative diagnoses.
4. The unit ID Team and the client, family, and/or authorized representative will be made aware of and participate in the diagnostic process and in treatment decision-making, according to NVTC policy.

  
Michael B. Kurtz, M.D  
Medical Director

  
Date

NVTC  
NURSING SERVICES  
SOP #30

**TARDIVE DYSKINESIA**

**POLICY:** Clients receiving anti-psychotic medications will be evaluated at least quarterly by nurses who have received special training, and at least annually by primary physicians and nurse practitioners at the time of the annual physical examination. If signs and symptoms suggesting tardive dyskinesia are detected, clients will be referred for further evaluation and treatment.

**PROCEDURE:**

1. Clients will be systematically assessed according to the DISCUS examination procedure or, if uncooperative, the client may be observed at a distance for five minutes.

2. Nurses will screen all clients receiving anti-psychotic medications on a quarterly basis, as set forth in Nursing Services SOP #28.

3. Physicians and nurse practitioners performing annual physical examinations on clients receiving psychotropic medications will observe involuntary movements, postural and muscular tone changes, and document them on NVTC Form 99.

4. Persons suspected of tardive dyskinesia will be referred for further psychiatric and/or neurologic consultation to confirm or refute the suspected diagnosis and to rule in or out alternative diagnoses.

5. The unit ID Team and the client, family, and/or authorized representative will be made aware of, and participate in, the diagnostic process and in treatment decision-making according to NVTC policy.

6. The unit nurse supervisor is responsible for keeping the client tardive dyskinesia screening list current and for coordinating the unit nurses screening schedule.

7. Nursing department tardive dyskinesia screeners are recertified every two (2) years as recommended by DISCUS certifiers.

8. This SOP operates in conjunction with the Health Services Dept. policy on Tardive Dyskinesia screening.

SOP #28

## NURSING SERVICES - STANDARD OPERATING PROCEDURE

### TARDIVE DYSKINESIA SCREENING

---

**PURPOSE:** To perform a standardized tardive dyskinesia examination.

**PROCEDURE:**

- New admissions and re-admissions to NVTC shall be evaluated for tardive dyskinesia at the time of admission by the health care practitioners.

- Clients at NVTC on anti-psychotic medication or metoclopramide shall be assessed at least quarterly by a registered nurse under the direction of the psychiatrist.

- Clients who are discontinued from anti-psychotic medications with a history of 90 days or longer cumulative exposure shall have a rating within 2 weeks, 6 weeks, 3 months, 6 months and 12 months after discontinuation.

- a) If a 12 month rating is negative, ratings may be discontinued.

- b) If a 12 month rating is positive, ratings shall be performed annually thereafter.

- The Dyskinesia Identification System: Condensed User Scale (DISCUS) shall be used as the assessment tool. (NVTC Form #99B)

- The dyskinesia monitoring record shall be filled out to provide long-term data on tardive dyskinesia. (NVTC Form #99C)

- All clients identified by the unit nurse as having signs of tardive dyskinesia will be referred to the consulting psychiatrist.

- This SOP operates in conjunction with the Health Services Dept. policy on Tardive Dyskinesia screening.

## MANAGEMENT PLAN OF CLIENTS WITH TARDIVE DYSKINESIA

---

For clients identified as having tardive dyskinesia, attempts will be made to decrease and ultimately discontinue anti-psychotic medication, unless there are documented medical and/or psychiatric conditions which would make the decrease and/or discontinuation not in the best interest of the client.

The family guardian or authorized representative of the client will be informed of the diagnosis and of the recommended plan for treatment by a member of the health services team.

Tardive dyskinesia monitoring will continue according to the procedure for tardive dyskinesia monitoring.

## Simplified Diagnoses for Tardive Dyskinesia (SD-TD)

**PREREQUISITES.** — The 3 prerequisites are as follows. Exceptions may occur.

1. A history of at least three months total cumulative neuroleptic exposure, include amoxapine and metoclopramide in all categories below as well.
2. **SCORING/INTENSITY LEVEL.** The presence of a **TOTAL SCORE OF FIVE (5) OR ABOVE.** Also be alert for any change from baseline or scores below five which have at least a "moderate" (3) or "severe" (4) movement on any item or at least two "mild" (2) movements on two items located in different body areas.
3. Other conditions are not responsible for the abnormal involuntary movements.

**DIAGNOSES.** — The diagnosis is based upon the current exam and its relation to the last exam. The diagnosis can shift depending upon: (a) whether movements are present or not, (b) whether movements are present for 3 months or more (6 months if on a semi-annual assessment schedule), and (c) whether neuroleptic dosage changes occur and effect movements.

- **NO TD.** — Movements are not present on this exam or movements are present, but some other condition is responsible for them. The last diagnosis must be **NO TD, PROBABLE TD, or WITHDRAWAL TD.**
- **PROBABLE TD.** — Movements are present on this exam. This is the first time they are present or they have never been present for 3 months or more. The last diagnosis must be **NO TD or PROBABLE TD.**
- **PERSISTENT TD.** — Movements are present on this exam and they have been present for 3 months or more with this exam or at some point in the past. The last diagnosis can be any except **NO TD.**
- **MASKED TD.** — Movements are not present on this exam but this is due to a neuroleptic dosage increase or reinstatement after a prior exam when movements were present. Also use this conclusion if movements are not present due to the addition of a non-neuroleptic medication to treat TD. The last diagnosis must be **PROBABLE TD, PERSISTENT TD, WITHDRAWAL TD, or MASKED TD.**
- **REMITTED TD.** — Movements are not present on this exam but **PERSISTENT TD** has been diagnosed and no neuroleptic dosage increase or reinstatement has occurred. The last diagnosis must be **PERSISTENT TD or REMITTED TD.** If movements re-emerge, the diagnosis shifts back to **PERSISTENT TD.**
- **WITHDRAWAL TD.** — Movements are not seen while receiving neuroleptics or at the last dosage level but are seen within 8 weeks following a neuroleptic reduction or discontinuation. The last diagnosis must be **NO TD or WITHDRAWAL TD.** If movements continue for 3 months or more after the neuroleptic dosage reduction or discontinuation, the diagnosis shifts to **PERSISTENT TD.** If movements do not continue for 3 months or more after the reduction or discontinuation, the diagnosis shifts to **NO TD.**

### INSTRUCTIONS

1. The rater completes the Assessment according to the standardized exam procedure. If the rater also completes Evaluation items 1-4, he/she must also sign the preparer box. The form is given to the physician. Alternatively, the physician may perform the assessment.
2. The physician completes the Evaluation section. The physician is responsible for the entire Evaluation section and its accuracy.
3. **IT IS RECOMMENDED THAT THE PHYSICIAN EXAMINE ANY INDIVIDUAL WHO MEETS THE 3 PREREQUISITES OR WHO HAS MOVEMENTS NOT EXPLAINED BY OTHER FACTORS. NEUROLOGICAL ASSESSMENTS OR DIFFERENTIAL DIAGNOSTIC TESTS WHICH MAY BE NECESSARY SHOULD BE OBTAINED.**
4. File form according to policy or procedure.

### OTHER CONDITIONS (partial list)

- |                                          |                                 |
|------------------------------------------|---------------------------------|
| 1. Age                                   | 12. Huntington's Chorea         |
| 2. Blind                                 | 13. Hyperthyroidism             |
| 3. Cerebral Palsy                        | 14. Hypoglycemia                |
| 4. Contact Lenses                        | 15. Hypoparathyroidism          |
| 5. Dentures/No Teeth                     | 16. Idiopathic Torsion Dystonia |
| 6. Down's Syndrome                       | 17. Meigs Syndrome              |
| 7. Drug Intoxication (specify)           | 18. Parkinson's Disease         |
| 8. Endocarditis                          | 19. Steroidosis                 |
| 9. Extrapyramidal Side-Effects (specify) | 20. Sydenham's Chorea           |
| 10. Fan's Syndrome                       | 21. Tourette's Syndrome         |
| 11. Heavy Metal Intoxication (specify)   | 22. Wilson's Disease            |
|                                          | 23. Other (specify)             |

(Rev. 10/27/71)

### DYSKINESIA MONITORING RECORD

Reg. #:

Unit #:

[illegible]

### SCORING SYSTEM

- 0 - Absent  
1 - Questionable  
2 - Mild  
3 - Moderate  
4 - Severe  
NA - Not Assessed

[illegible]

July 14, 1993

NVTC INSTRUCTION 5302

TO: Staff

SUBJECT: *Psychotropic Medication*

- I. Purpose. To establish definition, policies, and procedures for the use of psychotropic medication.
- II. Cancellation. NVTC Instruction 5302 dated March 4, 1993 is hereby canceled.
- III. Policy.
  - A. The use of psychotropic medications shall adhere to sound clinical standards. The assessment process and treatment course and appropriate follow-up of individuals receiving these medications shall be monitored closely by qualified professionals. These medications shall be prescribed and administered pursuant to professional judgment by appropriately qualified professionals in accordance with State and Federal regulations.
  - B. Psychotropic medications shall only be used:
    1. When less restrictive methods have been considered and tried when appropriate,
    2. as an integral part of a program plan designed by an interdisciplinary team to manage specific behavior(s) in the least restrictive manner and ultimately to eliminate targeted behavior(s).
    3. for the treatment of specific psychiatric disorder(s); or
    4. in an emergency situation only when the client presents a clear danger to himself or others and less restrictive alternatives have been considered, tried and/or are contra-indicated.
  - C. Psychotropic medications shall only be used if the harmful effects of the behavior clearly outweigh potentially harmful effects of the medication. Behavior modifying medications shall not be used:
    1. as a punishment;
    2. for staff convenience;
    3. as a substitute for behavioral, developmental, educational and/or therapeutic programs;
    4. excessively nor in quantities that interfere with an individual's habilitation program;
    5. in the absence of a systematic data collection method with which to evaluate medication efficacy.
  - D. Although the concurrent use of more than two psychotropic medications from different therapeutic classes is acceptable, this practice should not occur except in cases justified and documented by a psychiatrist.
- IV. Definition.

"Psychotropic medications" means medications which are prescribed by licensed physician(s) and administered for the purposes of modifying specific behavior(s) and treating specific psychiatric disorder(s). These include, but are not limited to, the following classifications of medications:

  - A. antipsychotic (neuroleptics, major tranquilizers);

- B. anxiolytics;
- C. antidepressants;
- D. anti-manic medication;
- E. anticonvulsants (when used as behavior management agent) or to treat specific psychiatric disorder(s);
- F. stimulants;
- G. sedative - hypnotics;
- H. certain somatic medications (when used as behavior management agent(s) or to treat specific psychiatric disorder(s)).

V. Procedure.

- A. The Interdisciplinary Team with leadership by the psychologist must identify the client's specific maladaptive behavior through a functional analysis of the behavior to determine a variety of solutions to the behavior problem.
- B. If psychotropic medication is viewed as a viable option, the client will be referred, through the attending physician and/or unit psychologist for complete psychiatric diagnostic evaluation.
- C. Psychotropic medication may not be ordered for more than one month. A renewal order by the physician must be based on collected data presented at the medication review, Interdisciplinary Team discussion (when indicated) or psychiatric consultation and must review any side effects incurred by the client.
- D. Side effects of psychotropic medication will be discussed with the Interdisciplinary Team and monitored by the unit nurse, physician, and the psychologist. Direct care also shall be made aware of side effects and instructed to bring their observations to the nurse or physician.
- E. Problematic issues associated with psychotropic medications that occur between scheduled reviews will be brought to the attention of unit attending physician who decide upon the necessity of an interim psychiatric consultation.

VI. Documentation.

- A. The attending physician will design a written medical plan for the client using the recommendations made by the psychiatrist. This medical plan will be an addendum to any existing behavioral plan interfacing with behavior management. If a behavioral program is not indicated for the problem, the physician will indicate this in the medical plan. If a behavioral program is indicated, the psychologist and physician will write separate but concurrent and interfacing program plans for behavior management. Specific content for physician and psychologists behavior management plans shall be elucidated in writing in departmental procedures. Both plans shall become part of the client's active treatment plan.
- B. If the client, or his/her guardian or authorized representative did not participate in the process of designing the medical and/or behavioral program plan(s), a statement of rationale for his/her not being included must be made by the responsible physician and/or psychologist on the appropriate plan.



C. The following approvals, consents and notifications are necessary prior to implementation of psychotropic medication and must be reviewed at least annually:

1. Interdisciplinary Team Approval:  
Must already include:
  - a. Physician's Approval;
  - b. Psychologist's Approval;
  - c. Psychiatrist approval
2. Approval of other clinicians as appropriate to other program plan components;
3. Behavioral Management Committee Approval;
4. Advocate Notification;
5. Client, (if over the age of 18 and not adjudicated incompetent), parent, legal guardian or authorized representative.
6. Director's approval when restrictive procedures of locked Time-Out, or mechanical restraints, and "personal restraints" are included in the behavioral plans (See NVTC Instruction 5300);
7. LHRC Review.

NOTE: Client/Parental/Guardian/Authorized consent is sought after a full presentation of the written plan. These individuals have the right to refuse consent for the administration of the medication(s) as described in the program. If consent is refused, after full description of the program and explanation of components as well as clinical soundness of the total program, NVTC may take action to appeal for a court adjudication on the issue.

D. The NVTC Tardive Dyskinesia monitoring procedure will be initiated.

E. If there are major deviations (changing type of medication and/or type of restrictive procedure) from the originally described program plans, new plans and procedures must be written to reflect these changes and all approvals, consents, and notifications must be secured for the newly developed plans just as for the original plans.

F. If designated levels of behavior(s) are reached (i.e., objectives are met) which entail alteration in procedures (reduced levels of medication, less restrictive procedures) which have been described in the plans, BMC, Advocate, LHRC, and parents/guardians or authorized representative will be notified of these changes in writing.

G. Emergency Uses of Psychotropic Medications:

1. Psychotropic medication may be used in emergency situations only when the client presents a clear danger to himself/herself or others and after all efforts have been made to bring behavior under control.
2. Standing or P.R.N. orders of a psychotropic medication may not be used.
3. The unit psychologist - or if unavailable, other NVTC psychologist, the Director MR Programs or the Director, NVTC - will contact the physician explaining the situation and requesting assistance from the physician in the form of psychotropic medication.
  - a. During regular working hours, the psychologist will contact the physician directly.
  - b. Outside of regular working hours, the psychologist will contact the Infirmary and request the nurse on duty to contact the physician on call.

4. If the physician concurs that psychotropic medication is indicated for the client, the physician will order an appropriate medication, including dosage, to be administered by nursing staff. The order will be written by the physician during regular working hours or may be placed by telephone to nursing staff outside of regular working hours. The physician will co-sign the order on the next working day if the order is given by phone.
5. After receiving the physician's order, the nurse will assess the client. If the medication, by then appears no longer necessary, then nurse will contact the physician for authority to cancel the medication.
6. The nurse will appropriately monitor the client after the medication has been given.
7. If emergency administrations of psychotropic medications are not included in the approved written plan, the physician or designee will notify the client's parents/guardians or authorized representative within twenty-four (24) hours of an emergency drug administration.
8. Following the use of psychotropic medication in emergency situations, an NVTC Event Report (Form #67A) will be prepared by unit staff and sent to the Risk Manager with copies circulated to the unit psychologist, unit physician, Program Manager, Advocate, and BMC. The Event Report will include a description of the behavior warranting the use of psychotropic medication and documentation of attempts to implement other procedures prior to psychotropic medication.
9. When three emergency orders of psychotropic medication are required within twelve months, the client's physician, & psychologist and psychiatrist must review the problematic behavior after the third incident with the ID Team and document the review in the CRS.
10. The pharmacist will review all emergency chemical interventions the next working day. The psychiatrist will review them at least weekly.

VII. Effective Date. This instruction will become effective on the date issued.



David H. Lawson, Ph.D.  
Director

DHL:LP/igt  
Health Services

NORTHERN VIRGINIA TRAINING CENTER  
FOR THE MENTALLY RETARDED

Medical Plan for Psychotropic Drug Use

Name: Unit: DOB: REG. NO.:

History of Psychotropic Drug use and Previous Behavioral Procedures Tried:

Name of Psychotropic Drug, Frequency, Dosage, Route of Administration and Plans to Achieve Therapeutic Level:

Target Maladaptive Behavior to be Modified:

Monthly Frequencies: See Psychologist's notes.

| Month | Total | Month | Total |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Name of Psychotropic Consultant: Dr. Howard I. Pressman

List of Potential Side Effects of the Psychotropic Drug:

a) Major Side Effects:

b) Minor Side Effects:

Medical Review of Side Effects (by whom, frequency, outcome of review) including Laboratory Work of Indicated:

**Medical Plan for Psychotropic Drug Use**

Plans to be Implemented in the Event of Side Effects:

Statement Regarding Resident's Harmful and Undesirable Behavior Overweighing the Drug's Potential Harmful Side Effects:

Concurrent Behavior Programs (if any) Designed by the Interdisciplinary Team for the Target Behavior: Psychologist's section

See activity schedules for the reinforcing environments.

See behavioral plans for the target behaviors \_\_\_\_\_,

\_\_\_\_\_  
(See section 5)

Medical Plans, including Objectives for Review based on Available Collected Behavior  
Data including Review Frequency, how documented and if possible, Plan for Readjusting,  
Reducing or Discontinuing the Drug:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Howard I. Pressman, M.D.  
Consulting Psychiatrist

**CONSENTS:**

By Resident:

a) Competent adult - consent signed ( ). Unable to make medical decisions ( )

By Parent/Guardian:

a) Psychiatry conference attended and verbal consent given ( ).

b) Consent given by telephone ( ).

c) Consent given in writing ( ).

**APPROVAL:**

By Interdisciplinary Team: \_\_\_\_\_ Date: \_\_\_\_\_

By Psychologist: \_\_\_\_\_ Date: \_\_\_\_\_

7 Approval: \_\_\_\_\_ Date: \_\_\_\_\_

ARC Approval: \_\_\_\_\_ Date: \_\_\_\_\_

Submitting Attending Physician: \_\_\_\_\_ Date: \_\_\_\_\_

NORTHERN VIRGINIA TRAINING CENTER

CONSENT FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION

I hereby give consent to Northern Virginia Training Center medical staff to administer \_\_\_\_\_

to:

The following adverse reactions which may occur have been explained to me by Dr.

In addition, I am aware of the small risk of unexpected and unpredictable side effects; including paradoxical reactions and the possible worsening of symptoms, which may occur. Alternative methods of treatment, if any, have been explained to me.

The anticipated benefits of the medication appear to outweigh the above risks. I therefore give my consent. I understand I can withdraw my consent at any time.

Clients signature (or mark) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**ADDENDUM TO MEDICAL PLAN FOR PSYCHOTROPIC DRUG USE**

NAME: \_\_\_\_\_ UNIT: \_\_\_\_\_ REG NO.: \_\_\_\_\_ PROBLEM #: \_\_\_\_\_

Previous behavioral procedures tried prior to institution of current psychotropic drug:

Current target maladaptive behavior to be modified:

|                                 |                                 |
|---------------------------------|---------------------------------|
| _____ Non-compliance _____      | _____ Property Damage _____     |
| _____ Self-Abuse _____          | _____ Toileting _____           |
| _____ Physical Aggression _____ | _____ Disruptive Behavior _____ |
| _____ Tantrums _____            | _____ Other _____               |

Current behavior programs by the ID Team for the target behavior:

Current medical plan including objective and plans for readjusting, reducing or discontinuing the drug:

Statement regarding resident's harmful and undesirable behavior outweighing the drugs potential harmful side effects:

Up to date consents by the parents/guardians:

By Whom: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_ Writing: \_\_\_\_\_ Verbally: \_\_\_\_\_

Date: \_\_\_\_\_ Physician: \_\_\_\_\_

## HEALTH SERVICES POLICY AND PROCEDURES REGARDING PSYCHOTROPIC MEDICATIONS

### POLICY

Psychotropic medications are ordinarily used as an adjunctive treatment within the framework of a previously arranged, interdisciplinary management program with a psychiatric diagnosis and target symptoms. Ordinarily, the medication having the most favorable benefit vs. side effects profile in the lowest effective dose for the shortest period necessary for each individual will be utilized. Sound medical judgment will be the primary decision-making criterion, both under ordinary circumstances and for determining exceptions.

### PROCEDURES

1. Interdisciplinary assessment and decision-making processes, tempered and guided by sound medical judgment, shall be employed in the initiation, adjustment, and withdrawal of psychotropic medications.
2. Decisions must be supported by objective data, to the extent practical, as well as by subjective observations and opinions, and must conform with sound medical judgment.
3. Involvement of client, family, and/or authorized representative will take place, as specified by law.
4. Review by the Behavior Management Committee and by the Local Human Rights Committee will take place, as specified by NVTC Instruction 5302.
5. The Medical Plan for Psychotropic Drug Use, Form #159, which also includes consent forms, will be completed by the psychiatrist or primary physician; the plan and consents will be updated at least annually on form #159A.
6. Emergency uses of psychotropic medications will be handled according to NVTC Instruction 5302.
7. The clinical course and dosages for all clients receiving psychotropic medications will be reviewed at monthly interdisciplinary medication review conferences by a psychiatrist and/or by the client's primary physician.
8. Monitoring by direct client observation for adverse side effects of psychotropic medications by nursing and medical staff members will regularly occur, at least as often as the quarterly physical assessment and tardive dyskinesia assessments by registered nurses and the annual physical examination by primary physicians; tardive dyskinesia assessments will be conducted according to HS Standing Order #28 and Nursing Services SOPs # 28 and 30.

9. Clients manifesting signs or symptoms suggesting possible new psychotropic medication side effects will be promptly referred for medical, psychiatric, and/or neurologic evaluation and treatment, if indicated.
10. Candidates for medication reduction and withdrawal may be individually identified according to the guidelines in 1 through 3, above, and such adjustments planned if the anticipated benefits to the client appear to exceed the risks of decompensation, in the judgment of the consulting psychiatrist.
11. An audit of the quarterly tardive dyskinesia screening program will be conducted semi-annually by the nursing department and the results submitted to the quality assurance committee.
12. An audit of psychotropic medication prescribing practices will be conducted annually by the pharmacy and therapeutics committee and the results submitted to the quality assurance committee.

Michael B. Kurtz, M.D.  
Medical Director  
2/28/95



NORTHERN VIRGINIA TRAINING CENTER  
**CRS IMPLEMENTATION TIMETABLE**  
(Attachment One)

| <b><u>PHASE</u></b>                          | <b><u>TIMETABLE</u></b>         | <b><u>STATUS</u></b>    |
|----------------------------------------------|---------------------------------|-------------------------|
| <b><i>I. Recruitment</i></b>                 | <b><i>August 1994</i></b>       | <b><i>completed</i></b> |
| <b><i>II. Research &amp; Development</i></b> | <b><i>December 1994</i></b>     | <b><i>completed</i></b> |
| <b><i>III. Training</i></b>                  | <b><i>March - June 1995</i></b> | <b><i>pending</i></b>   |
| <b><i>IV. Implementation</i></b>             | <b><i>July 1, 1995</i></b>      | <b><i>pending</i></b>   |
| <b><i>V. Quality Management</i></b>          | <b><i>30 - 90 days</i></b>      | <b><i>ongoing</i></b>   |

PROPOSED SECTION DIVIDERS  
AND PURGING SCHEDULE  
Ver.1.  
PART I - DEVELOPMENTAL  
(Attachment Two)

|                    |                  |
|--------------------|------------------|
| Facesheet          | updated annually |
| Assessment Process | removed          |
| MAP 121A/MAP 119   | permanent        |

**SECTION ONE**

**IDENTIFYING INFORMATION**

**PURGE SCHEDULE**

|                             |         |
|-----------------------------|---------|
| Identifying Info/Photograph | current |
| Visiting Information Sheet  | current |
| Daily Activity Schedule     | current |

**SECTION TWO**

**IHP/ASSESSMENTS/EVALUATIONS**

*filed alphabetically*

|                                         |         |
|-----------------------------------------|---------|
| IHP/IPP/IEP*not separated by discipline | current |
| Discharge Plan (filed with IHP)         | current |
| Restrictions of Rights/Freedoms         | current |
| Audiology                               | current |
| CABS                                    | current |
| Comprehensive Development Assessment    | current |
| Educational and Vocational Plans        | current |
| Occupational Therapy Comprehen Eval     | current |
| Physical Therapy Evaluation Form        | current |
| Psychological Evaluation                | current |
| Recreation Evaluation/Screening         | current |
| Speech/Language Evaluation              | current |

**SECTION THREE**

**PROBLEM LISTS/TREATMENT PLANS**

|                        |          |
|------------------------|----------|
| Goals/Objectives/Plans | one year |
|------------------------|----------|

filed by Prob# and Date

**SECTION FOUR**

**ID NOTES**

|                                          |          |
|------------------------------------------|----------|
| Interdisciplinary Notes                  | one year |
| Nutrition Quarterly Reviews (interfiled) | one year |
| Progress Reviews (behind ID Notes)       | one year |
| QMRP Quarterly Reviews                   | one year |

Ver.1  
PART II - MEDICAL

|                                 |                                                     |                              |
|---------------------------------|-----------------------------------------------------|------------------------------|
| <b><u>SECTION FIVE</u></b>      | <b><u>HEALTH ASSESSMENTS</u></b>                    | <b><u>PURGE SCHEDULE</u></b> |
|                                 | Physician Medical Review (physical exam)            | current                      |
|                                 | Psychiatric Evaluation                              | current                      |
|                                 | Psychiatric Annual Review                           | current                      |
|                                 | Ten Year Medical Summary                            | current                      |
|                                 | New Admission Medical Summary                       | current                      |
|                                 | Nursing Assessment                                  | current                      |
|                                 | Nursing                                             | current                      |
|                                 | Annual Nursing Review (IHP)( Devel Section)         | current                      |
|                                 | Admission Dental Review                             | current                      |
|                                 | Dental Annual Staffing Report(IHP-in Dev Sec)       | current                      |
| <br><b><u>SECTION SIX</u></b>   | <br><b><u>CONSULTATIONS/HOSPITAL REPORTS</u></b>    | <br>six months               |
|                                 | Medical Clinical Consultations(list)                | permanent                    |
|                                 | filed by chrono date not specialty                  |                              |
| <br><b><u>SECTION SEVEN</u></b> | <br><b><u>HEALTH GOPS/TREATMENT PLANS</u></b>       |                              |
|                                 | Goals/Objectives/Plans                              | one year                     |
|                                 | Psychotropic Drug Plan and Addenda                  | one year                     |
|                                 | Psychotropic Consents                               | one year                     |
|                                 | ID Notes-Psychotropic Medication and Reviews        | one year                     |
|                                 | ID Notes-Psychotropic Medication Probl List         | one year                     |
|                                 | Psychotropic Side Effects Summary Sheets            | one year                     |
|                                 | Psychiatric Weekly Notes                            | one year                     |
| <br><b><u>SECTION EIGHT</u></b> | <br><b><u>PHYSICIANS ORDERS</u></b>                 | <br>six months               |
| <br><b><u>SECTION NINE</u></b>  | <br><b><u>HEALTH ID NOTES</u></b>                   |                              |
|                                 | * Plan of Care/Recertification (interfiled by date) | one year                     |
|                                 | Nursing Monthly Reviews                             | one year                     |
|                                 | Nursing Assessment Form (quarterly)                 | one year                     |

|                         |                                                           |            |
|-------------------------|-----------------------------------------------------------|------------|
| <u>SECTION TEN</u>      | <u>MEDICATION RECORDS</u>                                 |            |
|                         | Pharmacist's Notes                                        | one year   |
|                         | Medication Administration Record                          | one year   |
|                         | Medication Record for Fever Routine                       | one year   |
|                         |                                                           |            |
| <u>SECTION ELEVEN</u>   | <u>CLINICAL LAB/X-RAY</u>                                 | six months |
|                         | Laboratory Data                                           | one year   |
|                         | EKG                                                       | one year   |
|                         | filed chono order Radiology (sonograms. ultrasounds. MRI) | one year   |
|                         |                                                           |            |
| <u>SECTION TWELVE</u>   | <u>GRAPHICS</u>                                           |            |
|                         | Seriously/Critically Ill                                  | current    |
|                         | Blood Pressure Graph                                      | current    |
|                         | Height/Weight                                             | current    |
|                         | Seizure Record                                            | current    |
|                         | Health Maintenance Record                                 | current    |
|                         | Diabetic Chart                                            | current    |
|                         | Drug Profile                                              | current    |
|                         | Graphic Chart                                             | current    |
|                         | Breast Examination                                        | current    |
|                         | Menstruation Record                                       | current    |
|                         | Tardive Dyskinesia Charts                                 | current    |
|                         | Psychotropic Side Effects Summary Sheets                  | current    |
|                         |                                                           |            |
| <u>SECTION THIRTEEN</u> | <u>CORRESPONDENCE/LEGAL</u>                               |            |
|                         | Consents                                                  | current    |

Appen  
SOURCE ORIENTED RECORD WITH INTEGRATED  
PROGRESS NOTES  
(Attachment Three)

ATTACHMENT  
33

**THE PLAN**

- MEDICAL, NURSING, DENTAL AND PHARMACY WILL DOCUMENT IN THE "HEALTH" SECTION.
- WITH THIS TYPE OF RECORD, EXCEPT FOR MEDICAL (HEALTH), EVERY DISCIPLINE DOCUMENTS IN THE ID NOTES.
- ID NOTES ADDRESSING EACH PROBLEM WOULD BE DOCUMENTED WITH THE CORRESPONDING NUMBER IN THE ID NOTES.
- MONTHLY REVIEWS ARE ALSO DOCUMENTED IN THE ID NOTES AND PREFACED WITH "OT MONTHLY REVIEW", ETC.
- QUARTERLY REVIEWS SUCH AS QMRP REVIEWS ARE CHRONOLOGICALLY FILED BEHIND THE ID NOTES FOR QUICK IDENTIFICATION.
- PROBLEM LISTS FILED TOGETHER IN ONE SECTION.
- DEVELOPMENTAL GOALS, OBJECTIVES AND PLANS (GOPS) FILED IN ONE SECTION.
- THE GENERAL LOG SECTION WOULD BE ELIMINATED.
- SOME OF THE INFORMATION THAT IS NOW KEPT IN THE UNIT LOG WOULD BE WRITTEN IN THE INTEGRATED ID NOTE SECTION.

**THE UNIT LOG:** WHAT IS DOCUMENTED IN THE UNIT LOG NEEDS TO BE DEFINED BY RESIDENTIAL SERVICES SO THERE IS UNIFORMITY IN THE "FORM" ITSELF AND THE DOCUMENTATION ENTERED INTO THE RECORD.

**NORTHERN VIRGINIA TRAINING CENTER****QUALITY MANAGEMENT PLAN****FY 94-95****I. Purpose:**

The purpose of the Quality Management Program for NVTC is to establish, organize, and implement an effective program through monitoring, evaluating, and documentation to improve the quality of life for each individual served.

**II. Goals:**

The goals of the NVTC Quality Management Program are as follows:

A. To organize and facilitate the systematic monitoring and evaluation of the quality and appropriateness of consumer services and client care and treatment in relation to established standards of care and practice.

B. To identify problems/risks and areas for improvement through gathering, aggregating and analyzing data.

C. To resolve identified problems/risks and to seize opportunities to improve consumer services and client care and treatment.

D. To document the process of problem/risk identification and quality improvement through resolution and follow-up.

E. To coordinate and integrate quality management into the ongoing operational activities of all clinical and support services.

F. To minimize the potential for liability to NVTC related to the provision of professional services.

G. To encourage the communication of information, findings and quality improvement efforts between services, departments and committees so as to increase clinical and administrative knowledge and to positively affect consumer services and client care and treatment.

H. To evaluate annually the effectiveness of the Quality Management Program.

### **III. Background:**

A. Quality Management is a dynamic process of monitoring and evaluating the habilitation and care programs and services provided to consumers and clients so as to produce strategies for change and improvement. Quality Management processes generally adhere to a problem solving module. Data from a variety of sources is utilized to identify existing problems, risks or potential for improvement. Once problem areas, risks or improvement opportunities are identified information is translated, assessed and analyzed so as to formulate a strategy for change. This problem-focused approach to Quality Management has five components:

1. Identification of existing/potential problems, risks or potential for improvement.
2. Assessment to determine the cause and scope of problems, risks or barriers to improvement.
3. Development and implementation of a corrective action or quality improvement plan.
4. Monitoring and follow-up to determine if desired results and outcomes have been achieved and sustained.
5. Documentation and communication of the results and outcomes of the quality management/improvement effort to appropriate management, staff and consumers.

B. It is the intent of NVTC's Quality Management Program that issues be addressed and resolved at the lowest possible level. Primary responsibility for providing quality services lies with the individual service provider and the responsible unit, team, department or service. Each unit, team, department and service must insure that services are developed in accordance with specific regulations, standards, policies, procedures, agency instructions, and Departmental Instruction No. 74 (QA/RM Program).

### **IV. Authority and Responsibilities:**

A. DMHMRSAS Commissioner. The ultimate authority of the administration of the Quality Management Program rests with the Commissioner DMHMRSAS. The Commissioner will delegate the authority for development and organization of the program to the Director of NVTC. The Commissioner shall, however, receive pertinent records and reports from the Director of NVTC concerning findings, activities and accomplishments.

B. NVTC Director. The Director of NVTC is recognized as the delegated and ultimate authority to represent the DMHMRSAS Commissioner at the agency level. The Director, in liaison to the

Commissioner, will establish, give direction to, monitor the activities of and routinely evaluate the effectiveness of the Quality Management Program to ensure continued evidence of improved consumer services and client care and treatment.

C. Quality Management Committee. The NVTC Director shall establish a Quality Management Committee for the purposes of implementing the NVTC Quality Management Program. The committee shall function as a direct liaison between units, departments and services and the Director of NVTC in regard to Quality Management matters. The committee's primary charge shall be to assure that suitable solutions are found for identified problems, risks and improvement opportunities and that corrective action and/or improvement plans are implemented.

1. Responsibilities of the Quality Management Committee are to:

a. Interpret the intent and application of standards and regulations.

b. Monitor facility compliance to standards and regulations and facilitate correction of deficits and/or the implementation of Quality Improvement Plans.

c. Administer priorities for Quality Improvement Activities.

d. Assist units, teams and departments in establishing their Quality Assurance and/or Quality Improvement activities.

e. Identify problems, risks and potential for improvement and advise management and standing committees of issues and/or situations requiring the attention of the appropriate committee.

f. Make expeditious reviews of serious unanticipated outcomes where client injury has occurred or client safety has been jeopardized.

g. Review, aggregate and analyze trend data related to the quality of consumer services and client care and treatment.

h. Monitor solutions to Quality Management problems and risks by the appropriate action authority.

i. Take action to implement Quality Improvement efforts on matters referred to the committee.



j. Plan, conduct and perform follow-up monitoring of formal internal program or service delivery audits and/or surveys as assigned by the NVTC Director.

k. Evaluate the effectiveness of the Quality Management and Quality Improvement efforts of NVTC annually.

l. Prepare periodic reports of status and quality management activities and accomplishments to appropriate NVTC and DMHRSAS staff.

m. Perform other activities as assigned by the NVTC Director.

2. The composition of the Quality Management Committee is as follows:

- a. Quality Management Director (NVTC Risk Manager), Chairperson
- b. Director, Community Programs
- c. Director, Social Work
- d. Facility Advocate
- e. Infection Control Nurse
- f. Training Coordinator
- g. Director, Resident Records Department
- h. Facility Director (Ex-Officio)
- i. Others (Indicated by Need or Function of Issue Being Addressed)

D. Quality Management Director. The Quality Management Director will have the responsibility for the overall operation of the Quality Management Program. He/she shall ensure the participation of all involved units, teams, departments and services in the program. The NVTC Quality Management Director is the facility Risk Manager. The responsibilities of the Quality Management Director shall be to:

- 1. Report directly to the NVTC Director.
- 2. Coordinate daily Quality Management activities.
- 3. Chair the Quality Management Committee.
- 4. Receive Quality Management data from committee members to review and to determine patterns indicative of problems, risks or opportunity for improvement.

5. Share data and information and participate in appropriate management, committee, and unit/team/department and service meetings where issues of quality service delivery are to be addressed.
6. Consult with units/teams/departments and services to determine Quality Management/Improvement issues.
7. Coordinate Quality Management reviews and surveys.
8. Assist supervisors in using quality management findings to improve service delivery.
9. Maintain records of completed Quality Management activities, reviews and accomplishments.
10. Prepare, review and update NVTC policies, procedures, plans and resource documents related to the Quality Management Program as required.
11. Report Quality Management findings, activities and accomplishments to appropriate NVTC and DMHMRAS staff.

V. Program Components:

A. Department-Based Quality Assurance Program. Each NVTC Department is responsible for developing and implementing its own Quality Assurance System so as to monitor operations and improve the quality of its service delivery on an ongoing basis. Numerous methodologies for accomplishing this task have been proven to be effective and it is not the purpose of this plan to dictate required methods or mandatory processes to specific Departments. The Quality Management Committee shall assist individual Departments in selecting an appropriate model and in formulating their written plans as requested. Copies of Departmental plans must, however, be provided to the Quality Management Committee and they are to adhere address the following areas:

1. Policy Statement. Statement should state that the quality and appropriateness of services provided by each Department are monitored and evaluated in an ongoing, systematic effort to promote high quality care, to act on opportunities to improve care and to resolve identified problems.

2. Responsibility. A responsible individual should be assigned overall responsibility for monitoring and evaluation activities. The plan should also indicate who is delegated the responsibility for day to day coordination activities, the development of monitoring indicators, data collection, analysis of information and documentation.

3. Scope of Services. This section describes the general services provided by the Department, the types of clients/others served, and the types of staff (i.e. professional, clinical, direct care, administrative, support, etc.) utilized.

4. Identification of Important Aspects of Care. The critical elements of work that the Department is responsible for accomplishing are identified. Generally, these are related to appropriate regulatory, accreditation, professional or auditing agency standards.

5. Indicators. A criterion of competent performance is established. This criterion ought to be easily observable, measurable, and outcome based.

6. Monitoring Methodologies. Data sources available to evaluate performance in relation to established indicators are to be identified. Information can then be routinely collected, evaluated and compared to established standards to assess quality, identify potential for improvement, and/or identify problems.

7. Evaluation. This may include examination of specified important events at the time of occurrence as well as an analysis of lesser information on a periodic basis to identify patterns and trends, assess quality, to identify opportunities to improve service and/or to identify problem areas.

8. Documentation and Reporting. Monitoring and evaluation activities must be summarized and recorded. Quality improvement efforts and accomplishments must be reported to the Senior Staff Manager on a periodic basis. The Senior Staff Manager shall then consolidate Department efforts and provide a written report detailing all Quality Improvement efforts within his/her area of responsibility to the Quality Management Committee quarterly. Relevant information shall be shared with the Facility Director, representatives from the Senior Staff Committee and with appropriate Department Managers as deemed to be appropriate.

9. Evaluation. Department Quality plans are to be evaluated and revised annually. Revisions may also be made throughout the year as new issues arise or as monitoring activities indicate that a change is warranted.

**B. Quality Management Committee Activities.** The responsibilities and composition of the Quality Management Committee are detailed in Section IV C of this plan. In order to implement the responsibilities of its charge the Quality Management Committee shall meet monthly to review formal and informal information sources that have been identified as having specific Quality Management implications. Written minutes from these meetings shall be prepared and provided to the NVTC Director. Data that is reviewed shall be analyzed so as to identify areas that require improvement and appropriate Units/Departments shall be tasked to develop the necessary corrective action and report that action to the Committee.

**1. Presentation of Formal Data Sources:**

**a. Quality Management Director (Risk Manager).** The Quality Management Director is responsible for the administration of the Quality Management function and for chairing Committee meetings. He/she shall establish a schedule for Committee activities, assign duties to the various team members and coordinate the preparation and follow-up of Committee reports. The Quality Assurance Director shall also be responsible for obtaining various reports required by the Quality Assurance committee in order to properly execute its function. Among these reports are:

- 1) Quality plans and reports from all NVTC Departments.
- 2) Reports of Quality efforts and accomplishments undertaken by other NVTC standing and management committees.
- 3) Written internal and external reviews conducted at NVTC.
- 4) Continuous Quality Improvement plans and reports prepared by Center Program Units and Total Quality Management projects.
- 5) Written communications related to the NVTC Quality Management effort prepared by management, regulatory, accreditation or program audit entities.

**b. Risk Manager.** The Risk Manager shall coordinate the various elements of the Risk Management plan. In addition the Risk Manager shall review:

- 1) Serious incidents and trend data from the Incident Reporting System.
- 2) Activities of the NVTC Safety Committee.

- 3) Activities of the NVTC Clinical Practices Review Committee.
- 4) Activities of the Workers' Compensation Review Committee.

c. NVTC Advocate. The Advocate shall make recommendations to the Committee in the realm of Human Rights which require immediate attention. At his/her discretion the Advocate may review specific cases deemed to be of concern. Specifically, the Advocate shall review:

- 1) Human rights complaint data trends.
- 2) Restrictive program trend data.
- 3) Activities/issues that the Local Human Rights Committee has referred to the Quality Management Committee.

d. Infection Control Nurse. The Infection Control Nurse shall review:

- 1) Infection surveillance data trends.
- 2) Activities/issues that the Infectious Disease Committee has referred to the Quality Management Committee.

e. Training Department Representative. The Training Department Representative shall review:

- 1) Active treatment and staff interaction data trends.
- 2) Activities/issues related to Active Treatment and Staff Development which warrant aggressive treatment by the Quality Management process.

f. Social Services Director. The Social Services Director shall review data and activities related to the QMRP and IHP processes. He/she shall make recommendations to the Committee related to client program assessment, development, delivery and change. Specifically, the Director of Social Work shall review:

- 1) QMRP data trends.
- 2) Activities related to the admission, transfer and discharge of clients.

- 3) Activities/issues referred to the Quality Management Committee by the Admissions and Ethics Committees.

g. Resident Records Director. The Resident Records Director shall review:

- 1) Client record audit data trends.
- 2) Activities/issues related to the maintaining of the integrity of client records.
- 3) Activities/issues referred to the Quality Management Committee by the Resident Records Committee and the utilization Review process.

h. Community Programs Director. The Community Programs Director shall review:

- 1) Complaint and comment trend data received from community educational and vocational placements.
- 2) Activities and issues of Quality Management concern that have been generated as a result of relations with the various Community Services Boards and, Licensing, Certification, Accrediting, and Reviewing bodies.

2. Informal Information Sources. A variety of informal information sources, in addition to those discussed above, are available to assist in evaluating agency performance. Among these are:

- 1) Committee Meeting minutes.
- 2) Observation of client services.
- 3) Interviews with staff, clients, family and consultants.
- 4) Department and unit logs.
- 5) Staff Duty Officer and Roving Team Leader reports.
- 6) Security Officer reports.

- 7) Problems encountered by similar agencies.
- 8) Literature reviews.
- 9) Media exposure.
- 10) Etc.

3. Problem Identification and Corrective Action. Opportunities for improvement and/or problem and risk areas identified in the review of the formal and informal data discussed above shall be identified by the Quality Management Committee and directed to the appropriate Unit/Department Manager in order to affect corrective action. The Committee shall generate a problem oriented report document that identifies the issue and provides the documentation as to why the problem was identified. The Unit/Department shall be responsible for identifying the factors causing the problem and for developing a corrective action plan to address the issue in question. The corrective action plan developed by the responsible Unit/Department must identify the actions that must be taken by the Unit/Department itself and those actions that must be completed by those outside of the affected Unit/Department. The plan shall identify the responsible individuals for completing the actions required and provide completion dates. The Quality Management Committee shall monitor the effectiveness of the actions taken by conducting follow-up evaluations.

C. Quality Management Activities of Management and Standing NVTC Committees. Several NVTC committees have been identified whose principle functions involve responsibilities that can have a significant impact upon the quality of the NVTC service delivery system in one capacity or another. The chairpersons of these committees have been charged with the responsibility to document and report activities and projects that have been undertaken and which are deemed to have Quality Improvement implication. Reports of these activities and accomplishments are to be forwarded to the Quality Management Director on a quarterly basis so that they may be incorporated as a part of the comprehensive NVTC quality effort. The Committees are listed below:

1. Admissions Committee
2. Behavior Management Committee
3. Ethics Committee
4. Research and Development Committee
5. Resident Records Committee
6. Infection Control Committee
7. Safety Committee
8. Workers Compensation Review Committee
9. Clinical Practices Review Committee
10. Pharmacy and Therapeutics Committee

11. Habilitation Committee
12. Equal Employment Opportunities Committee
13. Others as Identified by the Quality Management Committee

D. TQM/CQI projects and project leaders are assigned by the NVTC Director as deemed appropriate. The Quality Management Committee shall serve as resource individuals and as facilitators for the Project Leaders should those leaders desire to utilize the assistance available. The Quality Management Director shall maintain a file of various TQM/CQI models and methodologies and shall provide any required training or guidance to TQM/CQI Team Leaders and/or Project Teams as indicated. TQM/CQI Project Leaders shall provide quarterly reports to the Quality Management Committee related to project status and quality improvements accomplished as a result of the activities of the effort. (See Appendix A)

E. Unit-Based Habilitation and Active Treatment Program Continuous Quality Improvement Activities. Unit service delivery systems are evaluated on a periodic basis utilizing the concepts of the TQM/CQI method in accordance with the certification standards published by HCFA for Intermediate Care Facilities for the Mentally Retarded. This program audit is conducted by the NVTC Quality Management Committee but is accomplished with the participative contributions of Unit Managers, Clinicians and Direct Care Staff. The procedures for the conduct of these Unit-based reviews and Quality Improvement efforts are as follows:

1. The Quality Management Committee chooses a Unit in which to conduct a certification standard related survey and initiate a Continuous Quality Improvement effort. Several factors are utilized to make this selection:

- a. Quality Management indicators and trend analysis.
- b. Senior management preferences.
- c. Results of reviews from previous evaluations.
- d. Invitation by the Unit managers and/or treatment team.

2. The Quality Management Committee evaluates all trend data available so as to provide a focus for the Unit survey. Data to be examined includes but is not limited to:

- a. Event Report data.
- b. Employee injury data.
- c. Human Rights complaint data.



- d. Client restraint data.
- e. QMRP reports.
- f. Client Record System audit data.
- g. Active Treatment and Staff Interaction data.

3. A general meeting is conducted among the Quality Management Committee, the Unit ID Team and Residential Services staff. At this meeting the Unit Team is advised that they have been selected for a Continuous Quality Improvement effort and are provided with the details and procedures that will be utilized by the Quality Management Committee during the conduct of the survey and improvement effort. The trend data that had been previously analyzed by the Quality Management Committee shall be discussed and management, clinicians and Unit staff are encouraged to assess the quality status of the Unit. Participants are also given the opportunity to address and identify any obstacles that prevent improvement of care and treatment.

4. The Quality Management Committee conducts a series of on-unit and at-work observations, record reviews and program audits. Numerous observations are made on all shifts and full program audits and records reviews are conducted of between 20-40% of records. A Quality Management Client Review Checklist developed from the HCFA regulations and guidance to surveyors has been formulated and is used to conduct these audits. Audit results are shared with the ID Team principals as they occur.

5. The Quality Management Committee conducts a team meeting and identifies a few to several areas where problems and potential for improvement as identified in program audits, unit observations and in staff interviews appear to be concentrated. The identified areas are then chosen as recommended projects for Unit Team TQM/CQI Focus Group processing. The Quality Management Committee also identifies some possible resource individuals from among its own Committee as well as from other NVTC resources outside of the Unit being reviewed. In addition, some preliminary ideas for addressing problem areas are devised.

6. The Quality Management Committee meets with the entire Unit Team again and presents the results of the audit process, the identified potential TQM/CQI topics and the initial suggestions for how each topic area may be improved. Input is solicited from the Unit Team Members and TQM/CQI Focus Group topics are finalized. A leader for each Focus Group is identified and Unit Team members are permitted to choose the Focus Group with which they would like to participate. A member of the Quality Management Committee is assigned to each Focus Group and additional resource individuals are identified and invited to participate.

7. Each Focus Group, consisting of a mixture of management staff, clinical staff, personal care staff, members of

the Quality Management Committee and additional resource individuals meets, utilizing the TQM/CQI methods discussed earlier, for a period of about four to six weeks for the purpose of identifying process changes required in their project area. Each Focus Group shall prepare a series of suggestions/recommendations designed to achieve Quality Improvement related to their Focus Group topic.

8. The Quality Management Committee and the Focus Groups then meet as a whole and each Focus Group presents its recommendations. Recommendations are discussed and expanded upon by the whole group and the several recommendations are synthesized.

9. Many of the initial recommendations can be immediately implemented, and if this is deemed appropriate immediate change is instituted. Other recommendations may require the approval of higher level NVTC Management and if this is the case the recommendations are taken to that level by the Quality Management Committee. Likely, many of the recommendations will have to be adapted and redesigned.

10. Focus Groups shall continue to meet to advance more recommendations and to refine implementation. The Unit Team will eventually assimilate the accomplishments and recommendations of each Focus Group and develop a fluid and on-going Continuous Improvement Plan for the Unit that will implement all of the recommendations. The Unit Team shall address the Improvement Plan periodically at clinical and administrative meetings to insure that recommendations and efforts are not neglected. The Unit management shall revise the Continuous Improvement Plan as accomplishments are achieved and as new areas for improvement are identified.

11. Unit management shall provide copies of updated Continuous Improvement Plans and reports of efforts and activities related to the Quality Improvement project to the Quality Management Committee quarterly.

F. Other Formal Program or Service Reviews. These types of reviews are non-routine evaluations. They are normally a very formal process and they require the development of a specific evaluation format.

1. Topic Selection. Topics for formal review are either recommended by the Quality Management Committee or are assigned by the Director of NVTC. These reviews are indicated when:

a. There is statistical evidence to indicate that the problem of concern occurs frequently.

b. The problem is so severe (though perhaps not widespread) that the facility's clients or resources are at significant risk.

2. Development of Assessment Criteria. The criteria for selecting performance standards to be assessed must be such that the elements that are essential to producing quality care, treatment or service are evaluated. The criteria selected should be outcome based to the extent that this is possible, however, process (what the provider does and the degree to which this conforms to accepted standards) shall not be overlooked. Standards selected are to be ratified or confirmed as essential by those who are responsible for the service being evaluated. This is necessary, not only to be fair to those responsible for the service, but also to enlist their support for and commitment to the process.

3. Program and Documentation Review. Case Treatment or service delivery is evaluated and reviewed in accordance with the established criteria to determine what, if any deficiencies, problems or opportunities for improvement exists.

4. Identification of the Problem or Improvement Opportunity. Once identified, problems or improvement opportunities shall be briefly, but fully stated. Measures of the extent, location and frequency of the difficulty shall be utilized to complete this process.

5. Problem Analysis. The responsible unit, department or service must then determine what has caused the problem. No corrective action plan can be successful unless it is appropriate to the cause of the difficulty. The three most common causes of problems are defects in system processes, insufficient knowledge and deficient performance. Each of these areas must be evaluated.

6. Corrective Action Plan. Once causes of a problem have been identified, a corrective action plan can be developed and implemented. The unit, department or service shall fully document the procedures which shall be instituted to bring about resolution. The plan shall identify corrective actions to be taken, assign a responsible individual and establish the suspense dates for the completion of the actions. The unit, department or service may find that it does not have the resources available to fully correct deficiencies noted. Should this be the case, additional corrective action requirements shall be coordinated with the Quality Management Committee.

7. Follow-Up. The unit, department or service shall provide the Quality Management Committee with regular progress reports related to the implementation of its improvement plan. The schedule for the submission of these reports shall be

established on an individual basis as determined to be appropriate by agreement between the unit, department or service and the Quality Management Committee. Continued monitoring and evaluation shall be implemented by the Quality Management Committee or by the appropriate Senior Staff Committee representative to insure that the approved correction plan has been implemented and the corrections implemented have produced the required change.

**VI. Quality Management Program Evaluation:**

The effectiveness of the NVTC Quality Management Program must be formally evaluated on an annual basis during the period of August - September by the Quality Management Committee and by the Senior Staff Committee to insure that the collective effort has been comprehensive, cost effective and that it has achieved the desired goal of enhancing the quality of services provided by NVTC. This evaluation must also assess the degree to which the annual performance objects of the Quality Management Program have been realized. The results of this annual program evaluation shall be fully documented and utilized to revise the NVTC Quality Management Plan and to establish objectives for the following year.

**VII. Quality Management Program Documentation:**

A. Annual Report. The Quality Management Director is required to submit a formal Quality Management Program annual report to the DMHMRSAS Office of Quality Assurance. This report must be submitted in October of each year and consists of the following elements

1. A report of the activities and accomplishments of the Quality Management Program realized during the preceding semi-annual period. The report submitted shall be a synthesis of all of the efforts, activities and accomplishments generated by each of the Quality Management Program components detailed in this plan.

2. The results of the annual formal NVTC Quality Management Program evaluation of effectiveness.

3. A copy of the revised NVTC Quality Management Plan.

4. A listing of the planned objectives to be accomplished by the NVTC Quality Management Program during the following year.

B. Semi-annual Report. The Quality Management Director is required to submit an interim Quality Management Program report to the DMHMRSAS Office of Quality Assurance semi-annually. This interim report must be submitted in February of each year, and as

in the case of the annual report, consists of a compilation and synthesis of the activities and accomplishments realized by each of the NVTC Quality Management Program components.

**VIII. Quality Management Plan Revision.**

The NVTC Quality Management Plan shall be reviewed annually. Any revisions shall correspond to and be in accordance with the findings produced during the annual Quality Management Program evaluation. This does not preclude the plan from being revised and improved at any time that circumstances warrant.

All Quality Management Plan revisions shall be submitted to the NVTC Director and to the DMHMRSAS Commissioner as they are made.

**IX. Confidentiality:**

All information, both verbal and written, pertaining to the NVTC Quality Management Program shall be held confidential and is considered to be the sole property of this facility as part of DMHMRSAS. This information is protected from disclosure by specific exclusion from the Freedom of Information Act and is considered as privileged communication under the terms of the Code of Virginia, Section 8.01-581.16 and Section 8.01-581.17.

Revised: March 1995

## APPENDIX A

### TOTAL QUALITY MANAGEMENT/CONTINUOUS QUALITY IMPROVEMENT (TQM/CQI)

TQM/CQI is the terminology applied to the method of providing for a fluid, ongoing and continual enhancement of the quality, as defined by the customer (those who use and/or are impacted by the service), and achieved through a systematic analysis of the service delivery system processes by means of a team approach in which management leads and facilitates employees who are empowered to make a significant impact upon the nature and methods of the processes utilized.

1. Elements of a TQM/CQI Approach. Numerous TQM/CQI programs and models have been advanced. Most of them incorporate several, if not all, of the following elements:

a. Customer Oriented. In the TQM/CQI concept quality is defined as meeting and/or exceeding the customers' expectations. When this is accomplished the customer is satisfied that the system has done the correct things in the correct manner. Key to the approach is being able to:

1) Identify who the customers are. In general Customers are the ultimate target or beneficiary of the agency's service. Customers may also be those who assist in making the service available to the primary target and even anyone within the organization who receives or utilizes the work of another employee or team. simply stated, the customer is anyone who uses or is impacted by the service.

2) Identify the critical expectations of the customer. This means that the focus of Quality Improvement efforts must be at the point where services are actually delivered to the system's users.

3) Keep in touch with the customer. This means knowing them and viewing all that is delivered from their perspective. Any outcomes that are measured must be the outcomes that are experienced by the customer.

b. Team Approach. The TQM/CQI concept emphasizes the team approach to problem solving and decision making. The value in utilizing the team approach is that it allows the introduction of a broad knowledge base to the problem identification and problem solving process. Ideally, Team Members will be assembled from among a broad range of employees who have expertise in all of the several components of the system being evaluated. The team approach allows for the pooling of skills, talents and knowledge so as to permit the identification of more, if not all, of the hindrances to Quality Enhancement as well the introduction of a wider range of solution options. With proper guidance and

facilitation, teams can often tackle complex and chronic problems and generate effective, permanent solutions.

c. **Management Leads and Facilitates.** The TQM/CQI process is dependent upon management being willing to forego more traditional directing roles and assume a leadership style that supports and facilitates the group process. Some of the requirements for management in the TQM/CQI process include the following:

- 1) Adopt the TQM/CQI philosophy.
- 2) Demonstrate a support for and give direction to TQM/CQI process.
- 3) Demonstrate a participative attitude in the process.
- 4) Encourage ideas and theories for improvement.
- 5) Provide resources and other assistance necessary for the process to be successful.
- 6) Institute a program of education, training and self-improvement for employees.
- 7) Make changes based upon the recommendations generated in the process.

d. **Employees are Empowered.** The TQM/CQI method is based upon including all levels of employees into the process of identifying areas for improvement and soliciting their involvement in developing the mechanisms by which this may be accomplished. There are several principles that may be applied in order to empower employees:

- 1) Treat all employee with dignity and respect.
- 2) Provide employees with important work to do on critical issues.
- 3) Give employees discretion and autonomy over their tasks and resources.
- 4) Allow employees to find ways to better serve their customers.
- 5) Encourage employees to find and fix problems.
- 6) Enable employees to put their ideas into action.

- 7) Assist employees in building relationships and supports.

e. **Systematic Evaluation of Processes.** The TQM/CQI model incorporates the concept that the potential of eliminating mistakes and errors lies not in changing worker behavior but in improving the system through which work is done. Emphasis is placed upon evaluating and analyzing the workplace systems so as to change them in order to facilitate a process that will result in improved quality when the final product is delivered. Therefore, TQM/CQI methods center about a scientific or systematic approach to studying and evaluating processes. Decisions for change are based on data analysis rather than hunches, root causes to hindrances are sought rather than reacting to superficial symptoms and permanent solutions are sought rather than relying on quick fixes. Thus, the TQM/CQI approach involves the use of a number of scientific tools and data collection mechanisms in order to analyze system processes and evaluate the improvement generated when changes are implemented. Some of the data gathering and analytical systems used in the TQM/CQI method include:

- 1) Flowcharts - simple to construct charts that emphasize the major steps to a process.
- 2) Work Flow Diagrams - Show the movement of materials, people or information within a system.
- 3) Pareto Charts - Focus improvement efforts by ranking problems or their causes. It is a chart depicting a series of bars whose heights reflects the frequency or impact of the problem.
- 4) Cause and Effect Diagrams - pictorial displays of a list. They identify and organize the possible causes of problems.
- 5) Operational Definitions - Precise definitions of important terms and procedures used in a project. They simply describe what something is and how it is used.
- 6) Histograms or Frequency Distributions - Pinpoint problems by identifying where and when problems do and do not occur.
- 7) Time Plots - Are used to examine data for trends and patterns that occur over time.
- 8) Dot Plots - Show what values occur and how often. They are used to quickly examine the distribution or spread of data.



9) Checksheets - Structured forms that facilitate the recording and analyzing of data.

10) Scatter Diagrams - Display the relationship between two variables. The shape of the scatter indicates if and how the two factors are related.

f. Monitoring the Results of Improvement Strategies. Most TQM/CQI models consist of studying data to identify system problems and suggesting solutions that are believed to correct the system problems. Results (outcomes) are then evaluated and measured to assess if improvement has occurred. If improvement is realized, steps are taken to incorporate the changes permanently and retain the enhancements. If positive results are not achieved, the process is repeated and an alternative enhancement strategy is developed. To accomplish this objective it is imperative that performance indicators are:

- 1) The best indicators of performance
- 2) Outcomes that the identified customers desire and expect (customer oriented).
- 3) Operationally defined (clearly understood by all).
- 4) Easily identified
- 5) Measurable

g. Project Selection. Most successful TQM/CQI efforts are project based. The processes or subsystems that are best suited for TQM/CQI treatment are those that are utilized by a broad number of users throughout the service delivery system. The following are guidelines that are to be considered when considering TQM/CQI projects:

- 1) The project is considered to have a significant impact on improving the quality of life for clients and/or the quality of work for employees.
- 2) The project allows for the collection of data that can be easily measured in observable terms.
- 3) Results can be obtained in 4 to 6 months.
- 4) The process is not one that is currently under revision or scheduled to be substantially changed in the near future.

5) The process has clearly defined starting and ending points.

6) The project represents a process/subsystem that needs improvement. The redesign of an entire service delivery system is not likely to be benefitted by the use of the TQM/CQI method.

## **I. NVTC INITIATIVE**

### **Current Status**

The NVTC Community Integration Initiative is the NVTC downsizing project with the primary objective of reducing the resident census from 270 to 200 persons during a three-year period as determined in 1991 under Governor Wilder's administration.

### **Timelines**

#### **January 1992**

A special allocation was requested and appropriated from the 1992 General Assembly in order to support funding for community placements of individuals to reduce to a census of 200 over a three-year period (July 1993 to June 1996).

#### **February 1992**

From July 1, 1992 through June 30, 1993, a total of \$180,000 in start-up funds was made available to community planners for leasing of homes and purchasing furnishings, equipment, etc. A total of \$2,100,000 was also appropriated over a three-year period beginning July 1, 1993. This funding was to be utilized as Home and Community-based Medicaid Waiver match for all services that were appropriate for the individuals re-entering the community from NVTC.

#### **April 1992**

The State established a three-year budget, matching State General Funds with Medicaid Waiver funds to cover the re-entry to the community. The schedule involved three years, allocating funds for community placement of 30 persons for the first year (1993-1994), 20 for the second year (1994-1995) and 20 for the third year (1995-1996). Later this schedule was revised as individual needs and high costs of residential services required.

#### **September 1992**

A steering committee for the Initiative was formed. Membership consists of staff from the Northern Virginia Community Services Boards (CSBs), parents of individuals living at the Training Center, Virginia Office of Mental Retardation Services (OMRS) staff, the Northern Virginia ARC, Parents and Advocates of the Institutionalized Retarded (PAIR), private providers and staff of NVTC. The steering committee has met quarterly throughout the project.

**March-September 1993**

The NVTC Steering Committee required that detailed information about the quality and scope of community residential providers be sent to all families interested in the community re-entry. Also, families developed a set of questions to be asked of prospective program providers to assist them in making informed choices.

**March 1993**

Families, NVTC staff, private providers, and CSB staff began meeting to plan for the first round of placements of individuals interested in community re-entry (Continued throughout 1993).

**April 1993**

The first individual moved out of NVTC to a community placement via the Medicaid Waiver.

**December 1993**

A total of 10 individuals moved into community homes in calendar year 1993.

**December 1994**

Twenty-eight additional placements were finalized at the rate of two-to-three placements per month during this calendar year. All placements were in small community residences with intensive involvement of parents/families in choice and selection of providers.

**June 1995**

The total number of discharges has been 41 for the first two fiscal years of the Initiative. These 41 placements have depleted the first two years of funding of the special allocation.

**July 1995**

The remainder of the original funding from the special allocation funds for the third year of the Initiative will become available. These funds will serve approximately 12 additional persons.

A supplemental funding request of \$600,000 to assist in placing the remaining 17 persons was included in the FY96 NVTC Continuous Improvement Plan submitted to and approved in the 1995 General Assembly Session.

## **II. SCHEDULE FOR CONTINUED DOWNSIZING**

| <b>TARGET DATE DISCHARGED</b> | <b>NVTC CENSUS</b> | <b>TOTAL # DISCHARGED</b> |
|-------------------------------|--------------------|---------------------------|
| 6/1/95                        | 232                | 41                        |
| 7/1/95                        | 228                | 45                        |
| 10/1/95                       | 224                | 49                        |
| 1/1/96                        | 216                | 57                        |
| 4/1/96                        | 208                | 65                        |
| 7/1/96                        | 200                | 70                        |

## **III. PROCESS**

### **Collaborative Planning Emphasized**

The DMHMRSAS, five Northern Virginia Community Services Boards (CSB's), the NVTC Senior Staff, and representatives from the parent and advocates group of NVTC residents, spent 18 months planning the move into community residential settings (January 1992-September 1993).

### **Parent Involvement Emphasized**

Most NVTC parents had never considered the possibility that their sons and daughters with severe/profound mental retardation would ever live in the community. Many of the potential residents of NVTC for the Community Initiative had/have multiple disabilities with significant physical and behavioral problems. Frequent parent meetings established assurances that the community environment would be sufficiently supportive and help consumers attempt to attain personal goals (February/December 1993).

### **Family choice was Emphasized**

Many parents were empowered for the first time with choices for community residential options for their sons and daughters. Parents helped select providers and roommates configuration for the developing community homes (Beginning Summer 1993).

### **Individualized placements were designed**

Based on information regarding the consumer's friendship choices, needs, interest, etc., community placements were highly individualized. The staff at NVTC developed and sent a questionnaire to all family members, advocates or guardians of every person residing at NVTC. This questionnaire consisted of basic information describing the project and solicited feedback on community placement and choice of living options of the families for those individuals at the Center. Such questions as type of living arrangement (i.e., group home, foster home, supported living, etc.) desired by the families, as well as roommate selection and time frames were surveyed. About 50% of the questionnaires were completed and returned (Summer/Fall 93).

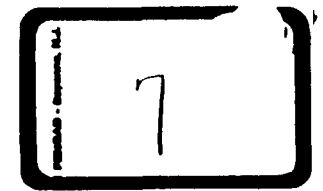
### **Persons Prioritized for Placements**

NVTC did not simply prioritize the "least disabled persons" for placements. Instead, with the involvement of families, a roster of individuals who were interested or volunteered for community placement was developed. The individuals on this list were discussed and described with each CSB that would be serving the individuals (Summer 1995 throughout project)

## **IV. OUTCOMES**

**By July 1, 1996**

- The census of NVTC will be reduced to 200 persons on schedule.
- Strong collaborative relationships have been developed between NVTC and Community providers. These relationships will greatly assist NVTC in further downsizing efforts.
- NVTC parents and families now understand that persons with severe disabilities can live in community options, due to the success of this Initiative.



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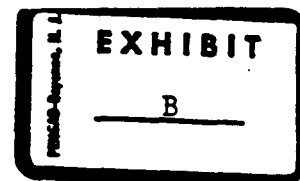
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IN THE UNITED STATES DISTRICT COURT FOR THE  
EASTERN DISTRICT OF VIRGINIA  
Alexandria Division

|                           |   |                           |
|---------------------------|---|---------------------------|
| UNITED STATES OF AMERICA, | ) |                           |
| Plaintiff,                | ) |                           |
|                           | ) |                           |
|                           | ) |                           |
| v.                        | ) | Civil Action No. 96-284-A |
|                           | ) |                           |
| COMMONWEALTH OF VIRGINIA, | ) |                           |
| <u>et al.</u> ,           | ) |                           |
|                           | ) |                           |
| Defendants.               | ) |                           |

O R D E R

In light of the Settlement Agreement entered by the parties on  
, 1996, which agreement is not so ordered or approved by  
the Court, this civil action is hereby DISMISSED WITHOUT PREJUDICE  
pursuant to Rule 41(a)(2) of the Federal Rules of Civil Procedure.

The Court retains jurisdiction over this civil action and the  
Settlement Agreement to resolve any disputes arising out of the  
Settlement Agreement and to enter a final dismissal of this civil  
action with prejudice as contemplated by the Settlement Agreement.  
Adjudication of and remedies for any alleged violation of the  
Settlement Agreement shall be subject to the procedures and  
limitations provided by the Settlement Agreement.

The Clerk is directed to remove this civil action from  
the court's active docket and to forward copies of this Order to  
counsel of record.

Entered this 4th day of June, 1996.

\_\_\_\_\_  
Leonie M. Brinkema  
United States District Judge

# APPENDIX B

## TABLE OF REPORTABLE PATIENT/RESIDENT INCIDENTS

| INCIDENTS                                                                                                                                                                                            | CATEGORY I EXAMPLES                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>All Deaths:</b><br><br>a) expected<br>b) unexpected<br>c) occurring within 7 days of discharge or elopement, if known                                                                             | Suicides<br>Violent Deaths<br>Accidental Deaths                                                                                                                                                 |
| <b>Loss of a limb or use of a limb, whether the loss is permanent or temporary:</b><br><br>a) All amputations<br>b) All fractures<br>c) Joint dislocations<br>d) Paralysis, paraplegia, quadriplegia | All except fingers and toes<br><br>Compound or multiple fractures<br><br>Requires emergency hospitalization or surgery<br><br>Permanent or disabling; extensive recuperation and rehabilitation |
| Spinal cord or serious back injury                                                                                                                                                                   | Permanent or disabling loss/impairment                                                                                                                                                          |
| Nerve injury or neurological deficit including loss or impairment to any sensory organ                                                                                                               | Permanent or disabling loss/impairment                                                                                                                                                          |
| Brain damage or serious head injury                                                                                                                                                                  | Permanent or disabling loss/impairment                                                                                                                                                          |
| Temporary or permanent disability or disfigurement (includes first, second, and third degree burns and other injuries)                                                                               | Second or third degree burns; life threatening                                                                                                                                                  |
| Internal injuries (e.g., torn ligament, bruised or ruptured internal organs, internal bleeding)                                                                                                      | Ruptured internal organs; life threatening emergency surgical repair                                                                                                                            |
| All serious wounds or lacerations requiring sutures                                                                                                                                                  | Emergency surgical repair; life threatening; disfigurement                                                                                                                                      |
| Sexual violation of a minor or a non-consenting or incompetent adult                                                                                                                                 | Forced encounter with injuries requiring acute medical treatment                                                                                                                                |
| Loss or impairment of a reproductive organ                                                                                                                                                           | Emergency surgical repair; permanent loss/impairment                                                                                                                                            |

## APPENDIX B

### TABLE OF REPORTABLE PATIENT/RESIDENT INCIDENTS

| INCIDENTS                                                                                                                                                                                                                              | CATEGORY I EXAMPLES                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <b>Self-injury:</b><br><br>a) Category I and Category II level injuries<br>b) Suicide attempts including those occurring 7 days after discharge or elopement, if known                                                                 | Emergency surgical repairs; emergency hospitalization; life threatening suicide attempts |
| Medication errors and drug reactions which require acute medical intervention. This includes, but is not limited to, episodes of drug toxicity, neuroleptic malignant syndrome, and overdose (prescription and non-prescription drugs) | Emergency hospitalization; stomach pump                                                  |
| All transfers for emergency medical care and all unexpected, unplanned inpatient hospitalizations for acute medical care                                                                                                               | Emergency surgery; hospitalization resulting from violent injury                         |
| Other adverse patient/resident incidents, to be determined by the circumstances and degree of liability exposure                                                                                                                       |                                                                                          |

#### Guideline for Determining Severity of an Incident (Refer to Section 18.7 A and B.)

The facility director or risk manager must determine whether reportable incidents should be classified as Category I or Category II events to determine reporting procedures. It also must be determined whether an incident meets or might meet the four elements of a professional or medical malpractice cause of action.

Category I Incidents are major crises or events including, but not limited to, those which are life threatening or potentially life threatening; require emergency or surgery; require extensive recuperation; are permanently disabling or disfiguring; or, where there is, or is likely to be, significant adverse press. Decisions about the degree of seriousness of an injury or medical incident should be made with physician and risk manager input. Category I incidents must be reported promptly to the Associate Commissioner, Community/Facility Services by telephone/pager and also entered into the CIBB.

Category II Incidents are the other reportable, serious incidents listed above. These are generally serious (but non-life threatening or permanently disabling) patient or resident injuries and situations that require medical and/or clinical intervention. Category II incidents are also reportable and must be entered into the CIBB.

## Departmental Instruction No. 33

### Reporting of Abuse of Clients

#### 33 - 1 Purpose

To establish policies, procedures and responsibilities for reporting and responding to allegations of abuse of clients in state mental health and mental retardation facilities.

---

#### 33 - 2 Definitions

The following definition applies to this instruction.

---

##### Abuse

- physical acts such as, but not limited to:
 

|            |              |          |          |
|------------|--------------|----------|----------|
| choking    | hair pulling | hitting  | striking |
| kicking    | pinching     | pushing  |          |
| scratching | slapping     | spitting |          |
  
  - sexual activity or any type of inappropriate touching such as, but not limited to touching, stroking or fondling of breasts, genitals or buttocks, directly or through clothing, of a client.
  
  - coercion, threats or intimidation that are statements or actions that would evoke fear in a reasonable person or that could reasonably be expected to evoke fear in the client.
  
  - neglect in care that is the failure to provide:
    - ☐ care
    - ☐ goods
    - ☐ services
    - ☐ treatment

necessary to the health, safety or welfare of a client.
  
  - statements or actions that would humiliate, demean or exploit a client.
  
  - condoning or permitting the abuse of a client, including client to client conflict, that may result in physical, emotional, or psychological harm.
-

October 20, 1994

### **33 - 3 Procedures - Facility Director**

*Any employee, volunteer, contract employee, consultant, visitor or relative who has knowledge or reason to believe that a client may have been subjected to abuse or other inappropriate behavior shall report such information IMMEDIATELY to the Facility Director. While it is recognized that this is not the normal flow of information and most staff members do not routinely report directly to the Facility Director, an allegation of possible patient abuse is so serious that any information regarding it should be given directly to the Facility Director so that immediate action can be taken to safeguard clients. The report of the alleged abuse shall describe the incidents as fully as possible, giving the names of the persons involved, the time, date and location of the incidents, and the names of any witnesses.*

**Upon Receipt of  
an Allegation**

**The Director shall:**

- immediately take steps to protect the safety and welfare of the client/s.
- immediately initiate action to protect any physical evidence.
- immediately notify the Advocate of the allegation and provide all the information obtained from the report.
- conduct a preliminary assessment in accordance with Departmental Instruction No. 114, *Generic Investigation Guidelines*.
- assure that the client's authorized representative is notified about any alleged abuse and informed that an investigation has been initiated. If the client does not have an authorized representative, obtain the client's permission to notify the family.
- confer with the Advocate within 24 hours of the report of the allegation.
- determine whether there is a reason to suspect that abuse has occurred.

**Upon a  
Determination  
There is Reason  
to Suspect Abuse  
Occurred**

**The Director shall -**

- immediately initiate an administrative investigation of the incident.

- immediately notify the local Department of Social Services in accordance with § 63.1-55.3 and § 63.1-248.3 of the *Code of Virginia* and the Interdepartmental Agreement between the Department of Social Services and the Department.
  - in all cases of suspected criminal activity such as sexual abuse, immediately contact local law enforcement authorities and/or State Police.
- 

If an Employee  
Has Been  
Identified as the  
Suspected  
Abuser

The Director shall -

- charge the employee with alleged abuse.
- immediately suspend the employee pending final disposition of the case.
- inform the employee of the charges and require him or her to cooperate with the administrative investigators.

Suspensions shall be in accordance with the Employee Standards of Conduct and Performance.

---

If the Director  
Determines that  
Abuse Has  
Occurred

The Director shall -

- meet and inform the employee of the finding and issue a Group III written notice under the Employee Standards of Conduct and Performance policy.

Such notice normally results in termination, however the Director has the discretion to mitigate the disciplinary action to an appropriate sanction other than termination.

- take any action necessary to prevent future occurrences.
- 

If Other Inap-  
propriate Acts  
Are Discovered  
in the Course of  
Investigation

The Director shall take appropriate administrative action under the Employee Standards of Conduct and Performance.

---



At Conclusion of  
Investigation.  
Regardless of  
Outcome

---

The Director shall -

- notify the client's authorized representative and the Advocate of the results of the investigation, the determination and the action taken.
- report all allegations made under this instruction, the results of any subsequent investigation, the determination, and the resulting action to the Associate Commissioner and the State Human Rights Director.

*Facilities who treat minors must notify the Licensure Office.*

---

### **33 - 4 Procedures - Advocate**

The Advocate shall -

- meet with the client and explain the role of the Advocate and the abuse investigation process.
  - represent the client during the investigation.
  - monitor the investigative procedures.
  - review the written investigative report.
  - conduct an independent investigation and submit a report of findings to the Director for review and consideration in making the determination of the disposition of the case, if deemed necessary.
  - discuss the decision of the Director with the client and advise the client of the right to pursue the matter through the Human Rights Review Process, if the client is dissatisfied with the Director's decision.
  - consult with the Director about the implementation of recommendations developed as a result of the investigation.
-

### 33 - 5 References

- *Code of Virginia*, §§ 63.1-55.3 and 63.1-248.3.
  - *Code of Virginia*, § 37.1 - 84.1.
  - Employee Standards of Conduct and Performance.
  - Departmental Instruction No. 114, "*Generic Investigation Guidelines.*"
- 

### 33 - 6 Distribution

A copy of this Departmental Instruction shall be given to each employee to be reviewed during the initial orientation. Employees' written acknowledgement of their understanding of this Instruction shall be placed in their personnel file.

A copy of this Instruction shall also be given to each volunteer, contractor, contract employee or consultant who will have direct contact with clients.

---

  
\_\_\_\_\_  
Timothy A. Kelly, Ph.D.  
Commissioner

This revised Instruction replaces Departmental Instruction No. 33, "Reporting of Abuse of Patients or Residents," issued November 15, 1991.

**EFFECTIVE DATE:** October 20, 1994

0223 Virginia Department of Mental Health.  
Mental Retardation and Substance Abuse Services  
Office of Management Information Services  
Incident - Detail Report  
NVTC  
From: 01/01/92 To: 01/15/92  
Incident Number: 25000009

Date: 05/30/1996  
Time: 14:05



Incident Date: 01/14/1992 Time: 11:15

Reporting Person: LEE HILTON

Patients Involved:

K [REDACTED] R

| Age | Building/Ward |
|-----|---------------|
| 33  | 3 C           |
| 0   |               |

Staff Involved:

NONE

Persons Contacted:

FAMILY

| Date       | Time  |
|------------|-------|
| 01/14/1992 | 16:00 |

LOCATION: BEDROOM

TYPE: FRACTURE/DISLOCATION

Description of Incident:

R [REDACTED] K [REDACTED] FELL IN BEDROOM

WHEN HIS FOOT BECAME TANGLED IN FURNITURE. AS HE FELL HIS  
LEG TWISTED CAUSING SPIRAL FRACTURE TO BOTH LEFT LEG BONES.

06-11-1996 14:15

70332

P.03/03

*Abuse/Neglect*

EVENT REPORT By Unit And Event FOR:

|                 |                                                                                                                                                                                       |               |          |     |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------|-----|
| CONTROL NUMBER  | 9407029                                                                                                                                                                               | EVENT-DATE    | 07/07/94 | THR |
| RESIDENT-NAME   | B [REDACTED] M [REDACTED]                                                                                                                                                             | DATE-CLOSED   | 07/21/96 |     |
| REG NO          | 000049                                                                                                                                                                                | UNIT          | 3D       |     |
| TIME-OF-EVENT   | 0720                                                                                                                                                                                  | LOCATION      | 3D       |     |
| TYPE-EVENT      | ABUSE ALLEGATN                                                                                                                                                                        | TYPE-INJURY   |          |     |
| INJURY-CAUSE    |                                                                                                                                                                                       | INJURY-LOCATN |          |     |
| NARRATIVE       | ROCHE LABORATORY PHLEBOTOMIST REPORTS THAT STAFF ON UNIT 3D WAS AGITATED AND UPSET. SHE PUSHED B [REDACTED] M [REDACTED]'S WHEELCHAIR ACROSS TS AND INTO A CHAIR IN AN ABRUPT MANNER. |               |          |     |
| COMMENTS-ACTION | FORMAL ABUSE INVESTIGATION CONDUCTED BY RISK MANAGER AND ADULT PROTECTIVE SERVICES. CHARGE WAS FOUNDED AND EMPLOYEE WAS DISMISSED. TERMINATION WAS EVENTUALLY UPHOLD BY CIRCUIT COURT |               |          |     |