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|---|---|
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## PURPOSE

The purpose of this directive is to establish the expectations of the South Carolina Department of Disabilities and Special Needs (DDSN) regarding interventions used to address concerning or problem behaviors exhibited by those served in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), those receiving Residential Habilitation in a DDSN-sponsored residential setting, and those for whom such interventions are necessary in order for them to participate in a DDSN-licensed employment/day program. Those interventions include:

- Behavior Support Plans which are defined as specific plans that teach or assist someone to build positive behaviors to replace or reduce problem behaviors and, when necessary, include strategies to be used to protect the person when dangerous and unsafe behaviors are exhibited.

- Psychotropic Medications which are defined as any medication used for the primary purpose of affecting overt maladaptive behavior, mood, or thought processes, or alleviating symptoms related to a specific diagnosed psychiatric condition.

- Emergency Interventions which are defined as procedures used to provide protection from harm in situations where the person is endangering him/herself or others with severely aggressive, self-injurious, or destructive behavior. These behaviors could not reasonably have been anticipated in the current setting and there is no approved behavioral, medical or psychiatric program in effect that provides adequate protection from harm.

- Health-Related Protections which are defined as restraint (chemical, physical, or mechanical) used during the conduct of a specific medical, dental, or surgical procedure or used out of necessity during the time a medical condition exists. Examples of devices used as a health-related protection include, but are not limited to: splints, braces, bed rails, wheelchair harnesses, helmets, and lap belts.

**NOTE**:

- Throughout this directive, DDSN Regional Centers and ICFs/IID operated by DSN Boards or contracted service providers will be referred to as "facility." When referring to agencies (DDSN, DSN Boards or contracted service providers) that provide Residential Habilitation and/or Employment/Day Services, "provider" will be used.

- Throughout this directive, "client representative" is used. In the context of this directive, "client representative" means the parent, guardian, legal counsel or other person who acts on behalf or in the best interest of a person with Intellectual Disability or a Related Disability (ID/RD) including Autism. This definition is consistent with S. C. Code Ann. § 44-26-10 et. seq. (2018).

- Client representative does not apply to those receiving services under the category of HASCI as there is no statutory authority for such.

**PHILOSOPHY**

Consistent with DDSN's values, it is expected that all supports and interventions to address problem behavior:

- Ensure the health, safety, and well-being of each person;
- Ensure that each person is treated with dignity and respect;
- Encourage participation, choice, control and responsibility;
- Encourage relationships with family and friends, and connections in the community; and
- Result in personal growth and accomplishment.

Consistent with DDSN's principles, it is expected that supports and interventions to address problem behavior will:

- Be person-centered and community inclusive;
- Be responsive, effective and accountable;
- Be practical, positive and appropriate;
- Be strengths-based and results-oriented;
- Offer opportunities to be productive and maximize potential; and
- Feature best and promising practices.

As a foundation of all supports, DDSN embraces positive behavior support. Positive behavior support recognizes that people exhibit problem behavior because it serves a useful purpose for them in their current situation/circumstances. The focus of positive behavior support begins with understanding the purpose or function of the problem behavior. Once it is known why the behavior occurs, interventions to promote positive behavior that serves the same function can be developed.

The goal of positive behavior support is not solely to eliminate problem behavior but to create environments and patterns of support that make the problem behavior irrelevant, inefficient or ineffective while making the positive behavior that is promoted as an alternative, relevant, effective and efficient.

DDSN believes that all who develop intervention strategies for people with disabilities must be knowledgeable in the values, theory, and practices of positive behavior support. Literature such as Functional Assessment and Program Development for Problem Behavior: A Practical Handbook (O'Neill, Horner, et. al., 2014) or similar guides to evidence-based practices in positive behavior support are recommended for review and study.

## POLICY

Those supported will be free from any serious risk to physical and psychological health and safety at all times, including while the function of the problem behavior is being determined and while the interventions to address the behavior are being developed.
DDSN prohibits the use of the following:

- Procedures or devices used for disciplinary purposes, for the convenience of staff, or as a substitute for needed supports;
- The use of medication for disciplinary purposes, for the convenience of staff, as a substitute for training or engagement, or in quantities that interfere with someone's quality of life;

- Seclusion which is defined as placing someone alone in a locked room;
- Enclosed cribs;
- Interventions that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
- Encouraging/using someone supported to discipline a peer;
- Prone basket-hold restraint (i.e., person held face down with arms folded under the chest);
- Time out rooms;
- Aversive consequences which are defined as the use or threatening the use of startling, unpleasant or painful consequences;
- As needed (PRN) orders for psychotropic medications or mechanical restraint except when prescribed by a physician while treating the person in a hospital setting or prescribed as part of the palliative care provided by Hospice;
- Use of psychotropic medications in the absence of a Behavior Support Plan for problem behavior and/or psychiatric symptoms that pose a risk to the person, peers, or the environment and interfere with the person's daily functioning;
- The planned use of restrictive procedures and/or restraint (manual or mechanical) prior to the exhaustion of less intrusive measures;
- The use of restraint (manual or mechanical) for more than one (1) continuous hour (60 continuous minutes);
- The use of restraint (manual or mechanical) when <u>not</u> necessary to protect the person or others from harm;
- Coercion/use of intimidation or use of force to gain compliance.

Each DDSN Regional Center, DDSN-operated Residential Services, DSN Board or contracted service provider of ICF/IID, Residential Habilitation and/or DDSN-sponsored Employment/Day Services shall adopt written policies and procedures governing the prevention and management of problem behavior. These policies and procedures shall focus on the prevention of problem behavior and specify the facility, program or DDSN-approved procedures that may be used. If consequence-based procedures are approved for use, the policies and procedures shall include each procedure on a hierarchy ranging from most positive/least restrictive to least positive/most restrictive. The policies and procedures shall address the use of restraint, the use of medications to manage problem behavior, and the practices prohibited by the facility, program or board/provider.

For ICF/IID residents, consent for programming, including Behavior Support, must be obtained pursuant to DDSN Directive 535-07-DD: Obtaining Health Care Consent for Minors and Adults.

In accordance with DDSN Directive 535-02-DD: Human Rights Committee, each facility or provider must designate and use a Human Rights Committee to review and approve planned interventions which involve risk to individual protection and rights. Pursuant to the DDSN Directive 535-02-DD: Human Rights Committee, the Human Rights Committee must review and approve of the use of planned interventions prior to implementation and appropriate consents/approvals have been obtained. Additionally, the Human Rights Committee must be notified of the use of any Emergency Interventions.

## I. BEHAVIOR SUPPORT PLANS

Behavior Support Plans must be developed and monitored in accordance with the regulations governing ICFs/IID when developed for ICF/IID residents and in accordance with DDSN Residential Habilitation Standards for those receiving Residential Habilitation.

Behavior Support Plans include specific procedures or techniques to be utilized to prevent and respond to behavior. These procedures or techniques may be nonrestrictive, restrictive, or employ restraint.

## A. BEHAVIOR SUPPORT PLANS: NONRESTRICTIVE

When the procedures or techniques within a Behavior Support Plan do not limit freedom, rights, or allow for the loss of access to personal property, the Behavior Support Plan is considered nonrestrictive. Examples of nonrestrictive procedures or techniques include, but are not limited to, teaching appropriate and functionally-equivalent replacement behavior; differential reinforcement, social disapproval, simple correction, re-directions and interrupting with educative prompts.

**NOTE**: Behavior Support Plans which accompany the use of psychotropic medications **ARE** considered restrictive.

Prior to implementation of a Behavior Support Plan that utilizes only nonrestrictive procedures/techniques for an ICF/IID resident, the Behavior Support Plan must be approved by the ICF/IID resident's Interdisciplinary Team which includes the person, his/her legal guardian or the person authorized to make health care decisions on behalf of the person, or client representative of a person with an Intellectual Disability/Related Disability and incorporated into the person's Individualized Program Plan (IPP).

Prior to implementation of a Behavior Support Plan for those receiving Residential Habilitation, the Behavior Support Plan must be approved by the person, client representative of a person with ID/RD, and the person responsible for the development of the Residential Habilitation Support Plan. If the Behavior Support Plan is to also be implemented by other service providers (i.e., Employment/Day Services providers), the Behavior Support Plan must be approved by the

person(s) who develop the Service Plan(s) for the other services (i.e., the person who develops the Individual Plan for Supported Employment if the plan is to be implemented as part of the provision of Employment Services).

Prior to the implementation of a Behavior Support Plan that utilizes only nonrestrictive procedures/techniques for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and participate in a DDSN-sponsored Employment/Day Service, the Behavior Support Plan must be approved by the person, client representative of a person with ID/RD, and the person who develops the Employment/Day Service Plan.

Behavior Support Plans that utilize only nonrestrictive procedure/techniques must be monitored in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, DDSN Residential Habilitation Standards, Day Activity Standards, etc.).

## B. BEHAVIOR SUPPORT PLANS: RESTRICTIVE

When the procedures or techniques within a Behavior Support Plan limit the person's rights, freedom of movement, or cause loss of access to personal property, the Behavior Support Plan is considered restrictive. Examples of restrictive procedures/techniques include, but are not limited to, increasing the level of supervision provided in response to behavior, one-on-one supervision, response cost, overcorrection, and separation lasting more than five (5) minutes (excluding time-out rooms which are prohibited).

**NOTE**: Behavior Support Plans which accompany the use of psychotropic medication **are** considered restrictive.

Prior to implementation of a Behavior Support Plan that includes restrictive procedures/techniques, appropriate approvals must be obtained.

Additionally, for ICF/IID residents, the Behavior Support Plan must be approved by the person's Interdisciplinary Team which includes the person, his/her legal guardian, or person authorized to make health care decisions on behalf of the person and the facility's Human Rights Committee.

For those receiving Residential Habilitation, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those receiving Residential Habilitation, the Behavior Support Plan must be approved by the person or his/her legal guardian and the person responsible for the development of the Residential Habilitation Support Plan. If the Behavior Support Plan is also to be implemented by other service providers (i.e., Employment/Day Service providers), it must be approved by the person responsible for developing the Service Plan or the other service (i.e., person who develops the Individual Plan for Supported Employment if being implemented as part of Employment Services). The Behavior Support Plan must be approved by the provider's Human Rights Committee.

For those who reside in their own homes (i.e., not receiving ICF/IID services or Residential Habilitation) and who receive DDSN-Sponsored Employment/Day Services, written informed consent must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and who receive DDSN-sponsored Employment/Day Services, the Behavior Support Plan must be approved by the person or client representative of a person with ID/RD, the person who develops the Employment/Day Service Plan, and the provider's Human Rights Committee.

Behavior Support Plans that include restrictive procedures/techniques must be monitored by the Human Rights Committee and in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, Residential Habilitation Standards, Career Preparation Standards, etc.).

## C. BEHAVIOR SUPPORT PLAN: RESTRAINT

Restraint is defined as a procedure/technique that involves holding someone (i.e., manual restraint) or applying a device (i.e., mechanical restraint) that restricts the free movement of or normal access to a portion or portions of one's own body.

Only when necessary to protect the person or others from harm and only when the procedure/technique is the least restrictive/intrusive alternative possible to meet the needs of the person may restraint procedures/techniques be included in Behavior Support Plans.

**NOTE**: The use of mechanical devices to support proper body positioning, even when movement may be restricted, is not considered restraint. Devices used for proper body positioning must only be used when the medical necessity for the device is clearly documented.

**NOTE**: Restraint (manual or mechanical) procedures may be included in Behavior Support Plans as a planned response to behavior that will immediately result in harm. Mechanical restraint procedures may also be included in Behavior Support Plans to address behavior that does not immediately result in harm, but due to the chronic/long term nature of the behavior (i.e., hand mouthing that results in skin breakdown, head banging, removing/picking post-operative sutures, etc.), will result in harm.

When restraint procedures (manual or mechanical) are included in Behavior Support Plans, the Behavior Support Plan must include strategies directed toward decreasing or eliminating their use. These Behavior Support Plans must also include provisions for the use of less intrusive techniques prior to the application of the restraint when the problem behavior is occurring.

When restraint procedures (manual or mechanical) are included in Behavior Support Plans as a planned response to problem behavior that will immediately result in harm, the plan must direct that, when applied, the person will be released from the restraint when he/she is calm and no longer dangerous (not to exceed one continuous hour). When mechanical restraint procedures

are utilized, the procedures must be designed and used in a manner that causes no injury and minimizes discomfort.

When mechanical restraint is utilized as a response to behavior that will immediately result in harm, the Behavior Support Plan must specify how the person will be supervised during the time the mechanical restraint is applied. The person's response to the restraint application and his/her physical condition (i.e., breathing, circulation) must be monitored at least every 30 minutes. Documentation of response and condition must be completed and maintained.

When mechanical restraint is utilized in response to chronic/long term behavior that will result in harm, the Behavior Support Plan must specify the schedule for the use of the mechanical restraint. The schedule must provide for release from restraint for 10 minutes every hour. The Behavior Support Plan must include the specific plan for supervising the person when the restraint is not in use (i.e., during times of release) and specify that the restraint is not to automatically be reapplied unless the behavior recurs. The person's response to restraint application and his/her physical condition (i.e., breathing, circulation), must be monitored at least every 30 minutes. Documentation of response and condition must be completed and maintained.

When, for an ICF/IID resident, a physician-ordered mechanical restraint is employed during sleeping hours to avoid interruption of sleep, release from the restraint is not required every hour. However, the application of the restraint must be monitored every 60 minutes (1 hour) to ensure it is properly applied and the person is comfortable.

When, for those receiving Residential Habilitation, mechanical restraints are employed during sleeping hours to avoid interruption of sleep, release from the restraint is not required every hour. However, the application of the restraint must be monitored every 60 minutes (1 hour) to ensure it is properly applied and the person is comfortable.

Prior to the implementation of a Behavior Support Plan that includes restraint (manual or mechanical) procedures, appropriate approvals must be obtained.

For ICF/IID residents, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with an Intellectual Disability/Related Disability, or the person authorized to make health care decisions on behalf of the ICF/IID resident.

Additionally, for ICF/IID residents, the Behavior Support Plan that includes manual or mechanical restraint must be approved by the person's Interdisciplinary Team, which includes the person, his/her legal guardian or person authorized to make health care decisions on behalf of the persons and either the DDSN Regional Center Facility Administrator or the Executive Director of the facility. The Behavior Support Plan must be approved by the facility's Human Rights Committee.

For those receiving Residential Habilitation, written informed consent for the Behavior Support Plan must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those receiving Residential Habilitation, the Behavior Support Plan that includes manual or mechanical restraint procedures must be approved by the person or client representative of a person with ID/RD, the staff responsible for developing the Residential Habilitation Support Plan, the Executive Director of the Residential Habilitation provider, and the provider's Human Rights Committee.

If the Behavior Support Plan requires implementation by other service providers (i.e., Employment/Day Service providers), it must also be approved by the staff responsible for developing the service plan for the other service (i.e., the person who develops the Day Activity Plan of Service) and as appropriate, the other service provider's Executive Director/CEO.

For those who reside in their own homes (i.e., not receiving ICF/IID services or Residential Habilitation) and who receive DDSN-Sponsored Employment/Day Services, written informed consent must be obtained from the person or client representative of a person with ID/RD.

Additionally, for those who reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation) and receive DDSN-sponsored Employment/Day Services, a Behavior Support Plan that includes restraint (manual or mechanical) must be approved by the provider's Human Rights Committee, the person or client representative of a person with ID/RD, the provider staff responsible for developing the Employment/Day Service Plan and the Executive Director of the Employment Day Service board/provider.

Behavior Support Plans that include restraint (manual or mechanical) procedures must be monitored by the Human Rights Committee and in accordance with the regulations or standards governing the program/service in which the Behavior Support Plan is implemented (e.g., ICF/IID Regulations, Residential Habilitation Standards, etc.). Additionally, the use of restraint procedures will be monitored by DDSN. When a Behavior Support Plan which includes restraint procedures (manual or mechanical) is approved, the approved Plan must be submitted to DDSN within 20 business days of approval. When the restraint procedure is employed, its actual use must be reported to DDSN. A report of the use of planned manual or mechanical restraint will be made to DDSN quarterly. Reports must be made to DDSN by the 15th day of January, April, July and October for any planned restraint employed during the previous quarter.

| | |
|---|---|
| January 1st – March 31st | April 15 |
| April 1st – June 30th | July 15 |
| July 1st – September 30th | October 15 |
| October 1st – December 31st | January 15 |

## II. PSYCHOTROPIC MEDICATION

Before psychotropic medications are used as an intervention to address problem behavior, the potential risks of those medications must be carefully weighed against the risk of the behavior for which the medication will be given. The specific concerning behaviors/symptoms for which the medication will be given must be documented along with the consideration of the associated risk.

When psychotropic medications are given, DDSN Directive 603-01-DD: Tardive Dyskinesia Monitoring, must be followed.

When given, psychotropic medications must be reviewed based on the person's needs as determined by the psychiatrist or physician but must be reviewed at least quarterly. Through this review, the Psychotropic Drug Review, the combination of the psychotropic medication and Behavior Support Plan are monitored using the behavioral data collected as part of the Behavior Support Plan for effectiveness with addressing the specific behaviors/symptoms for which the medication is given. The Psychotropic Drug Review should provide for gradually diminishing medication dosages and ultimately discontinuing the medication unless clinical evidence justifies that the medication is necessary. The Psychotropic Drug Review should be completed with those who know the person well. Those involved in the Psychotropic Drug Review should include, but are not limited to, the physician and/or psychiatrist, the person and/or his/her legal guardian, the person responsible for the Behavior Support Plan, the person responsible for the ICF/IID Individual Program Plan or Residential Habilitation Support Plan, the ICF/IID Nurse and a direct support professional who knows the person well. The health care provider responsible for prescribing the psychotropic medication is responsible for ensuring compliance with the Adult Health Care Consent Act.

For ICF/IID residents, when psychotropic medication is given, a Behavior Support Plan is also required. The Behavior Support Plan must address the behaviors/symptoms for which the medication is given. In combination, the psychotropic medication and the Behavior Support Plan should lead to a less restrictive/intrusive way of managing and, if possible, eliminating the problem behavior and/or psychiatric symptoms for which they are employed.

For those receiving Residential Habilitation in a DDSN-sponsored residential setting, when psychotropic medication is given to address problem behavior that poses a significant risk to the person (i.e., self-injury), others (i.e., physical aggression), or the environment (i.e., property destruction), a Behavior Support Plan is required. The Behavior Support Plan must address the specific behaviors/symptoms for which the medication is given. In combination, the psychotropic medication and the Behavior Support Plan should lead to a less restrictive/intrusive way of managing and if possible, eliminating the behaviors/symptoms for which they are employed. For those receiving Residential Habilitation, a Behavior Support Plan is not required in conjunction with psychotropic medication when the person's record clearly documents that he/she:

- Does not exhibit behavior that poses a significant risk to him/herself, others or the environment, and/or;

- Has reached the lowest effective dosage of the medication based on data regarding the occurrence of the specific behavior/symptoms for which the medication is prescribed which is confirmed in writing each quarter by the physician/psychiatrist prescribing the psychotropic medication.

When, for those receiving Residential Habilitation, a Behavior Support Plan is not used in conjunction with psychotropic medication, the specific behavior/psychiatric symptoms targeted

for change by the use of psychotropic medications must be clearly noted. Data must be collected on the occurrence of those behaviors/symptoms targeted for change. The collected data must be provided as part of the Psychotropic Drug Review to inform the decisions made therein. Any other problem behavior, especially those which pose a significant risk to the person, others, or the environment, must also be documented and shared as part of the Psychotropic Drug Review.

When psychotropic medications are prescribed for those who participate in a DDSN-sponsored Employment/Day Program and reside in their own homes (i.e., not receiving ICF/IID or Residential Habilitation), efforts must be made to obtain information about those medications and the specific problem behaviors or symptoms for which they were prescribed. If those behaviors/symptoms interfere with the person's ability to fully benefit from Employment/Day Services or are sufficiently severe to likely jeopardize the person's ability to continue to live in his/her own home, the need for Behavior Support Services must be discussed with the person's case manager.

**NOTE**: Services are available through:

- State Funded Community Supports;
- State Funded Follow Along;
- Intellectual Disabilities/Related Disabilities (ID/RD) Waiver;
- Community Supports Waiver; or
- Head and Spinal Cord Injury (HASCI) Waiver.

## III. EMERGENCY INTERVENTIONS

DDSN Directive 567-04-DD: Preventing and Responding to Disruptive Behavior and Crisis Situations, establishes the requirement that all DDSN-operated facilities/programs, DSN Board operated facilities/programs and DDSN-qualified service providers utilize a DDSN approved system for teaching and certifying staff to prevent and respond to disruptive behavior and crisis situations. Only the techniques that are part of a DDSN-approved system may be used in situations where someone is endangering him/herself or others with severely aggressive, self-injurious, or destructive behavior and, because the behavior could not have reasonably been anticipated, there is no approved plan or program in effect that provides adequate protection from harm. When manual restraint techniques are employed as an emergency response, the Facility Administrator or the provider Executive Director must be immediately notified. Within 24 hours of the incident, a written report of the incident must be provided to the Facility Administrator/Executive Director and either the person's Interdisciplinary Team or the staff responsible for the person's service plan development.

The emergency use of manual restraint is considered a critical incident and must be reported to DDSN in accordance with DDSN Directive 100-09-DD: Critical Incident Reporting.

As soon as possible following the emergency use of manual restraint, the person's legal guardian must be notified of the incident. With the consent of the person, his/her family or correspondent should be notified of the incident unless the person communicates that they do not want their family to be contacted. If the person is unable to communicate, the family will be contacted. The person must be provided any needed augmentative or alternative communication devices/technology to assist in that dialogue.

The facility or provider's Human Rights Committee must be notified of the emergency use of manual restraint. The notification must be made in accordance with facility/board/provider policy.

Each time manual restraint is used as an emergency response, consideration must be given to the circumstances under which the incident occurred and the frequency with which the emergency use of manual restraint is necessary for the person. Once a pattern emerges or when manual restraint is employed twice in a 30 day period or employed three (3) times during any three (3) consecutive month's period, a specific plan must be developed to prevent and/or respond to the behavior.

In rare circumstances, psychotropic medications or mechanical restraints may be used to provide protection from harm in unanticipated situations where the person is endangering him/herself or others. Prior to use, authorization by the Facility Administrator or provider Executive Director must be given. When possible, prior written authorization should be given. When not possible, prior verbal authorization may be given, but must be followed with written authorization that is completed, signed, and available within 24 hours of the verbal authorization. The written authorization must justify the use of the emergency intervention including the less intrusive measures that were tried but failed. The written authorization must include the specific medication and dosage to be given or the specific mechanical restraint to be applied. If prior verbal authorization was given, the time of the verbal authorization must be included. The authorization must specify the date and time period for which the authorization is valid; authorizations may not exceed 12 hours.

When mechanical restraint is authorized as an emergency intervention, the restraint may only be applied until the person is calm and no longer dangerous or for a maximum of one (1) continuous hour. While the restraint is applied, the person's response to its application and his/her condition must be monitored at least every 30 minutes. Documentation of the monitoring must be maintained.

The emergency use of psychotropic medications or mechanical restraint is considered a critical incident and must be reported to DDSN in accordance with DDSN Directive 100-09-DD: Critical Incident Reporting.

As soon as possible following the emergency intervention, the person's legal guardian must be notified of the incident. With the consent of the person, his/her family or correspondent should be notified of the incident unless the person communicates that they do not want their family to be contacted. If the person is unable to communicate, the family will be contacted.

The facility or provider's Human Rights Committee must be notified of the emergency use of these interventions. The notification must be made in accordance with facility/board/provider policy.

Each time these interventions are used as an emergency response, consideration must be given to the circumstances under which the incident occurred and with which emergency interventions are necessary for the person. Should a pattern emerge, or if mechanical restraint or psychotropic medications are employed in response to an emergency twice in a 30 day period or three (3) times during any three (3) consecutive month's period, a specific plan must be developed to prevent and respond to the behavior.

## IV. HEALTH RELATED PROTECTIONS

When during the conduct of a specific medical, dental or surgical procedure or during the time in which a medical condition exists, the person requires protection, restraint (chemical, manual or mechanical) may be used. These health related protections must be ordered by the person's physician/dentist. The physician/dentist must specify the schedule for its use and how the use of the protection is to be monitored. Examples of restraints that may be used as a health-related protection include, but are not limited to, splints, braces, bed rails, wheelchair harness, helmets, lap belts and abdominal/torso belts. Because the primary purpose of a health-related protection is not to manage behavior, a Behavior Support Plan is not required.

For an ICF/IID resident receiving services in a DDSN Regional Center, DDSN Directive 603-03-DD: Medical and Dental Treatment of Uncooperative Consumers, must be followed.

Gary C. Lemel
Vice Chairman
(Originator)

Eva R. Ravenel
Chairman
(Approved)

***To access the following attachments, please see the agency website page "Current Directives" at https://www.ddsn.sc.gov/about-us/directives/current-directives.***

Attachment: Reporting the Use of Planned Restraint