BEHAVIORAL PROTECTIVE SUPPORTS AND PROCEDURES

I. POLICY STATEMENT

It is the policy of the Office for Citizens with Developmental Disabilities (OCDD) to use behavioral protective supports and procedures only when necessary to protect an individual or others from injury.

- Behavioral protective supports and procedures may only be used in response to a crisis presenting an imminent and grave risk of injury to self or others.
- Behavioral protective supports and procedures may not be used as part of a behavior support plan as a contingent consequence to effect a behavior change.
- Behavioral protective supports and procedures may not be used in lieu of appropriate treatment and/or behavioral supports, as coercion, discipline, punishment or for the convenience of or retaliation by staff.
- The use of behavioral protective supports and procedures that limit mobility or access is strongly discouraged and limited to use as a last resort when other methods have been determined to be ineffective in assuring health and safety.
- To that end the use and type of behavioral protective supports and procedures must be the least restrictive and intrusive to the person’s dignity, liberty and autonomy that are effective in preventing injury. OCDD strongly discourages the use of 4 and 5 point behavioral protective supports and procedures except in the most emergent/dangerous situations.
- The use of prone containment is strictly prohibited.

II. PHILOSOPHY

OCDD is committed to offering quality services that promote each individual’s opportunity for personal growth and freedom. Inherent to this mission are systems that encourage personal choices, uphold individual rights, and promote personal safety. When an individual’s actions endanger his or her safety or the safety of others, a conflict between personal freedoms and safety may arise. The most caring response is to prevent injuries from occurring, even if this may necessitate the temporary use of behavioral protective supports and procedures. Behavioral protective supports and procedures should only be implemented within the context of stringent limitations designed to protect the
individual’s rights and safety. Well-constructed supports shall also be developed to prevent the recurrence of violent episodes and to promote long-term solutions.

III. PURPOSE

The purpose of this policy is to establish standards for the safe and appropriate application of behavioral protective supports and procedures and for the development of plans for reducing and/or eliminating the need for behavioral protective supports and procedures through effective prevention and treatment services. These standards:

- affirm the rights of individuals served by OCDD;
- establish limitations on the use of behavioral protective supports and procedures;
- prohibit the use of seclusion;
- establish procedures for developing, implementing and evaluating plans for treating behaviors and/or altering conditions resulting in protective supports and procedures;
- establish qualifications for staff who may use behavioral protective supports and procedures;
- establish procedures for the documentation and oversight of the use of behavioral protective supports and procedures; and
- establish procedures for evaluating the success of OCDD in reducing and/or eliminating the use of behavioral protective supports and procedures for each individual served.

IV. DEFINITIONS

**Behavior Intervention Committee (BIC)** - The Behavior Intervention Committee reviews, approves, and monitors individual programs designed to manage inappropriate behavior. This committee includes persons qualified to evaluate published behavior treatment research studies and the technical adequacy of proposed behavioral interventions.

**Behavioral Protective supports and procedures** - Behavioral protective supports and procedures are those used to suppress an individual’s behavior, not to include protective supports and procedures utilized when conducting a medical treatment or to promote healing exclusively during the course of a medical illness or injury. Behavioral protective supports and procedures may be planned or unplanned and may involve personal, mechanical, or chemical protective supports and procedures.

**Behavior Support Procedures (BSP)** - Behavior Support Procedures are formal behavioral intervention techniques developed by an interdisciplinary team to treat an individual’s identified challenging behaviors.

**Chemical Protective supports and procedures** - Chemical protective supports and procedures are those that involve the use of any medication to non-selectively suppress an individual’s behavior. This includes: (1) the use of medications to achieve a general suppression of behavior via sedation, in response to an individual’s behavior; (2) the long term use of medications for
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managing behavior without evidence of effectiveness; and (3) the use of medications that lack research support to treat a DSM IV diagnosis or specific behaviors. Chemical protective supports and procedures does not include: (1) medications prescribed in accordance with standard medical practice for the treatment of a medical condition or for the conduct of a medical test (Note: standard medical practice refers to procedures commonly employed with people in the greater community and does not include separate standards or protocols devised for individual with developmental disabilities); (2) psychotropic medications to selectively treat a DSM-IV diagnosis or specific behaviors for which research supports their use; (3) the use of medications supported by a pharmacological/ biochemical hypotheses based on published empirical or theoretical research; (4) the use of “minimal sedation/anxiolysis” (see definition in this policy); and (5) medications typically classified as psychotropic prescribed to treat conditions other than mental disorders (e.g., diazepam for spasticity or haloperidol to treat Huntington’s Chorea.). 1

**Exclusionary Time-out** - Exclusionary time-out is a restricted programmatic procedure involving the contingent use of an enclosed area (i.e., time-out room) following a challenging behavior. Exclusionary time-out is not a protective supports and procedures technique and its use is not regulated by this policy. This procedure shall meet the most stringent guidelines for use as defined by the State of Louisiana’s Guidelines for Behavioral Support and The Council on Quality and Leadership in Supports for People with Disabilities.

**Human Rights Committee (HRC)** - The Human Rights Committee reviews, approves, and monitors individual programs that involve risks to individual protection and rights. This committee includes individuals and/or their representatives, persons not affiliated with the agency, and persons with training or experience with issues and decisions regarding rights.

**Individualized Support Plan (ISP)** - The Individualized Support Plan is a plan developed by the interdisciplinary team, which includes the individual and representatives from the professions, disciplines or service areas that are relevant to: (1) identifying the individual’s wants and needs; and (2) meeting these wants and needs. 2

**Informed Consent** - Informed consent is consent given following the presentation of information to an individual or his/her legal guardian relevant to the individual’s services and their consent for implementation of the plan. At minimum, the information presented shall include the essential

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1 For a more comprehensive discussion of chemical protective supports and procedures see “Psychotropic Medications” in the State of Louisiana’s Guidelines for Behavioral Support: A Person Centered Approach. Also, refer to Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook.

components necessary for understanding the potential risks and benefits of the plan. Also, the individual or legal guardian shall be informed of the right to withhold or withdraw consent at any time. When presenting information for consent, it shall be presented in a manner that: (1) maximizes the individual’s or legal guardian’s understanding of the information provided; and (2) ensures that the individual or legal guardian is responding voluntarily.

**Interdisciplinary Team (IDT)** - The interdisciplinary team is a group of people (professional, paraprofessional and non-professional) working together to develop, continually review and revise as necessary an individual life plan that is most appropriate for the specific needs of the person to be served. With a person-centered focus, team membership is determined by the needs and desires of the individual. The individual being served and his/her family, advocates or significant others are essential members of the IDT.

**Mechanical Protective supports and procedures** - Mechanical protective supports and procedures involve the application of any physical device to the body of an individual for the purpose of restricting or suppressing the individual’s movement and/or preventing normal access to the body. OCDD authorizes the use of the following mechanical protective supports and procedures: bite blocks, helmets (with or without a face mask), mittens, multi-point protective supports and procedures, Papoose board, posey device/ankle cuff, posy device/wrist cuff, soft stockinettes, and wheelchair with seatbelt.

**Medical Protective supports and procedures** - Medical protective supports and procedures are those applied as a health-related protection that are prescribed by a licensed physician, licensed dentist or licensed podiatrist. Such protective supports and procedures are only used when absolutely necessary during the conduct of a specific medical or surgical procedure, or when absolutely necessary for the individual’s protection during the time that a medical condition exists. 3

**Orthopedic Appliances** - Orthopedic appliances include any mechanical device designed to improve mobility, to increase postural support or to minimize a physical disability; they are not considered protective supports and procedures. They must be recommended by a licensed occupational or physical therapist and prescribed by a physician. The individual’s need for an appliance and logistics concerning where, when, what and how an appliance is to be utilized shall be clearly documented.

**Personal Protective supports and procedures** - Personal protective supports and procedures involves the application of body pressure to an individual for the purpose of restricting or suppressing the person’s movement. This does not include approved techniques such as physical

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guidance, redirection and escorts involving brief holds of less than 30 seconds in which no aggressive resistance is observed. Transports are not considered protective supports and procedures unless the person verbally refuses or aggressively resists the transport.

**Planned Behavioral Protective supports and procedures** - Planned Behavioral Protective supports and procedures is the anticipated use of protective supports and procedures in response to an individual’s behavior, not to include protective supports and procedures utilized when conducting a medical treatment. Plans involving behavioral protective supports and procedures shall be developed into a crisis by the interdisciplinary team as part of the Individual Program Plan.

**Psychologist’s Authorized Designee** - A Psychologist’s Authorized Designee is a staff person who acts in place of the licensed psychologist and is responsible to the psychologist for the authorization and/or review of protective supports and procedures. Criteria to serve in this capacity are as follow: (1) approval of the licensed psychologist responsible for the individual’s behavioral and psychological services; (2) approval of the agency’s administrator; and (3) training and/or experience appropriate to the psychological needs of the individual(s) served.

**Protective supports and procedures** - Protective supports and procedures is the direct application of a physical hold (personal protective supports and procedures), mechanical device (mechanical protective supports and procedures), and/or medication (chemical protective supports and procedures) for the purpose of restricting or suppressing an individual’s movement or preventing an individual access to his/her body.

When more than one type of protective supports and procedures is used in succession, the most restrictive procedure is counted. Physical holds are considered the least restrictive protective supports and procedures procedure and chemical protective supports and procedures are considered the most restrictive. Thus, if a physical hold is used while applying a mechanical device, this is counted as a one mechanical protective supports and procedures. However, all procedures that are used during the episode are documented.

The following is a partial list of actions that are sometimes confused with protective supports and procedures, but are not protective supports and procedures:

- the use of orthopedic appliances or medical procedures in accordance with standard medical practices in the community;
- approved techniques such as physical guidance, redirection and escorts involving brief holds of less than 30 seconds in which no aggressive resistance is observed; and
- transports (physically moving an individual from one place to another) whereby no aggressive resistance is observed and/or the individual does not verbally or nonverbally (e.g., gestures, pulling away, vocalizing dislike when touched) refuse the transport.
Seclusion - Seclusion refers to the involuntary confinement of an individual in a locked room and is prohibited. Seclusion does not include exclusionary time-outs (as defined by this policy) implemented as part of an approved Behavior Support Plan.

Unplanned Behavioral Protective supports and procedures - An unplanned behavioral protective supports and procedures (often referred to as an emergency protective supports and procedures) is the unanticipated use of protective supports and procedures to prevent self-injury and/or physical aggression. Such protective supports and procedures have not been included in an approved Behavioral Support Plan or Individual Program Plan.

V. STAFF TRAINING AND COMPETENCE

Staff involved in the application of behavioral protective supports and procedures shall be trained and competent in methods for minimizing the use of behavioral protective supports and procedures and safely applying behavioral protective supports and procedures and in policies concerning the use of protective supports and procedures. Parents, guardians, and others who provide natural supports are also encouraged to participate in training.

OCDD will maintain documented evidence relevant to a staff member’s competency in implementing behavioral protective supports and procedures prior to his/her use of behavioral protective supports and procedures with an individual. The following describes required competencies:

- Staff shall demonstrate knowledge concerning the conditions necessary for implementation of behavioral protective supports and procedures.
- Staff shall demonstrate competency in the use of procedures taught in the standard State approved program(s) for managing aggressive behaviors. This includes competency-based training in:
  1) procedures for preventing, de-escalating and/or mediating when emotional behaviors are displayed that may precipitate more aggressive acts;
  2) procedures for safely applying physical holds as a form of behavioral protective supports and procedures; and
  3) knowledge of the signs indicating physical distress when an individual is immobilized using a behavioral protective support or procedure (i.e., verbal complaints, difficulty breathing, loss of bladder control, choking, lack of responsiveness or alertness, and skin discoloration).
- Staff shall demonstrate competency in the use of specific types of mechanical behavioral protective supports and procedures before applying such devices. Staff shall know how and when to apply the behavioral protective supports and procedures, when to release the individual, how to document behavioral protective supports and procedures, procedures for monitoring the individual during behavioral protective supports and procedures and other information pertinent to the safety of administering the behavioral protective supports and procedures.

- Staff shall complete a competency-based behavioral support training curriculum that involves didactic learning, demonstration and role play procedures designed to teach:

  1) values associated with effective behavior support planning;
  2) characteristics and benefits of enriched environments;
  3) skills for encouraging positive interactions with individuals served;
  4) strategies for helping individual with developmental disabilities acquire new skills;
  5) strategies for reducing challenging behaviors;
  6) procedures for selecting strategies for behavior support;
  7) procedures for identifying and documenting challenging behavior; and
  8) details concerning formal Behavior Support Procedures including their purpose, essential components of the plans and the importance of reliable implementation.

- The licensed physician, registered nurse or licensed practical nurse providing assessment of individuals’ health during and after behavioral protective supports and procedures shall demonstrate knowledge of OCDD’s behavioral protective supports and procedures policy and be proficient in the following:

  1) taking vital signs, respiration, circulation, mental status and interpreting their relevance to the physical safety of the individual in behavioral protective supports and procedures;
  2) recognizing nutritional/hydration needs;
  3) assessing physical and psychological status and comfort;
  4) recognizing when to contact additional medical staff or emergency medical services in order to evaluate and/or treat the individual’s physical status; and
  5) documenting the process and outcomes.

- Staff responsible for visually and continuously monitoring the person in behavioral protective supports and procedures shall demonstrate competence in the following:
1) knowledge and implementation of OCDD’s behavioral protective supports and procedures policies;
2) application of behavioral protective supports and procedures;
3) recognizing signs of distress;
4) recognizing when to contact a physician or emergency medical services in order to evaluate and/or treat the individual’s physical status; and
5) documenting the process and outcomes.

- Staff shall demonstrate knowledge/competency in first aid, cardiopulmonary resuscitation, and procedures for accessing emergency medical services rapidly.

All staff involved in the use of behavioral protective supports and procedures receive training at least annually and demonstrate 100% proficiency on competency-based performance evaluations concerning the use of behavioral protective supports and procedures.

VI. THE USE OF BEHAVIORAL PROTECTIVE SUPPORTS AND PROCEDURES IN INTERMEDIATE CARE FACILITIES

Policy requirements concerning the application of behavioral protective supports and procedures are divided into two sections: Limitations on the Use of Behavioral Protective supports and procedures and Procedures for Monitoring and Evaluating the Use of Behavioral Protective supports and procedures. For ease of reading, the subsequent use of the term licensed psychologist in sections A and B refers to a licensed psychologist or the Psychologist’s Authorized Designee. It is the policy of OCDD that a Psychologist’s Authorized Designee may be appointed in accordance with the criteria specified in the DEFINITIONS section of this document. This staff person acts in place of, and is responsible to, the licensed psychologist for the authorization and/or review of behavioral protective supports and procedures.

A. Limitations on the Use of Behavioral Protective supports and procedures

1. Prior to the implementation of a behavioral protective supports and procedures, staff shall demonstrate competence in administering and documenting the use of behavioral protective supports and procedures.

2. Behavioral protective supports and procedures shall be utilized only when:
   a. less restrictive procedures can not effectively prevent injury; and
   b. the individual’s behavior is potentially injurious to self or others.

3. Behavioral protective supports and procedures shall not be written as a standing order or on
an as needed basis (i.e., PRN). **This does not prohibit authorized crisis intervention plans.**

4. All individuals receiving services through OCDD shall be assessed by a physician to determine if any form of behavioral protective supports and procedures is contraindicated. These assessments shall be repeated at least annually and shall be updated as needed depending on the medical status of the individual receiving services.

6. Use of behavioral protective supports and procedures(s) shall be formally incorporated into the Individual Life Plan as a crisis intervention plan, if the need for behavioral protective supports and procedures is anticipated by the interdisciplinary team (i.e., more than 3 episodes involving protective supports and procedures in a 3 month period). The Life plan shall include behavioral support procedures for preventing the need for behavioral protective supports and procedures, acquisition training relevant to the behaviors leading to behavioral protective supports and procedures, other interventions. The crisis intervention procedures shall include a description of the specific behavioral protective supports and procedures(s) to be used.

7. Planned behavioral protective supports and procedures shall require informed consent and the approval of the Interdisciplinary Team (IDT), the Behavior Intervention Committee (BIC) and the Human Rights Committee (HRC). Approvals shall weigh the risks of behavioral protective supports and procedures versus the risks of not using behavioral protective supports and procedures and the appropriateness of the procedure as used in the plan:
   a. The IDT’s decision that the harmful effects of the behavior clearly outweigh the harmful effects of the procedure shall be documented in the individual’s record.
   b. Prior to the approval of behavioral protective supports and procedures, the IDT shall consider whether issues related to the individual’s age, maturity, ethnicity, history of physical or sexual abuse, health and/or physical disability contraindicate the use of protective supports and procedures.

8. Prior to the implementation of long-term chemical behavioral protective supports and procedures, an extensive rationale shall be provided to the IDT, the BIC and the HRC detailing the following:
   a. past treatment attempts including both psychoactive medication and behavioral

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4 For a comprehensive description of authorized practices for the development and implementation of behavior control and intervention procedures, refer to Louisiana’s *Guidelines for Behavioral Support: A Person Centered Approach.*
interventions and their outcomes; and
b. evidence that the risks of using medications to non-selectively suppress behavior clearly outweigh the risks of alternative treatment options.

9 Emergent (short-term, one time) chemical behavioral protective supports and procedures shall only be implemented when other measures have proved ineffective or are contraindicated as determined by the licensed psychologist. They shall be limited to emergencies in which there is imminent risk of harm to an individual or to others in proximity of the individual.

10. If unplanned behavioral protective supports and procedures are required in rapid succession and there is a high likelihood of the need for further behavioral protective supports and procedures before the standard approval procedures can be followed, an interim approval procedure shall be followed.

11. An interim approval process shall conform to the following minimum guidelines:

a. The IDT shall meet and weigh the potentially harmful effects of the behavioral protective supports and procedures against the harmful effects of the dangerous behavior. The IDT’s decision that the harmful effects of the behavior clearly outweigh the harmful effects of the procedure shall be documented in the individual’s record.

b. The IDT shall consider the least intrusive, effective procedure necessary to safely address the individual’s dangerous behavior. The procedure shall be incorporated into the Individualized Life Plan.

c. The individual’s licensed physician shall determine and document that the use of the procedure is not medically contraindicated.

d. The proposed plan shall be submitted to Chairperson(s) of both the BIC and HRC or their designee(s).

e. These two chairpersons or designees from each committee shall review the proposed behavioral procedures and may grant temporary approval for implementation. The date of expiration of this temporary approval shall be specified and may not exceed 30 calendar days.

f. The individual’s behavior support staff shall train and qualify staff members in the proper implementation of the plan and monitor implementation.

B. Monitoring and Evaluation of Behavioral Protective supports and procedures

Authorized behavioral protective supports and procedures as allowed within the limitations specified in this policy are subject to the following standards concerning monitoring and evaluation.
1. Behavioral protective supports and procedures require direct, continuous visual monitoring and documented checks every 15 minutes by qualified direct support staff (unless otherwise specified in the person’s ILP with a clinically justifiable rationale).

2. Steps for the authorization and initial review of behavioral protective supports and procedures are:
   a. Direct support staff (or other personnel with the individual requiring protective supports and procedures) shall contact their on-site supervisor and the licensed psychologist immediately, once the situation is under control;
   b. The licensed psychologist shall assess issues concerning the use of the behavioral protective supports and procedures and, based on the information provided, determine steps or procedures to be followed (e.g., continuing with the Behavior Support Plan, debriefing the individual, no change in procedure, additional steps, additional observations, further assessment, changes in treatment strategies, consultation, medical assistance, etc.).
   c. When personal behavioral protective supports and procedures are in progress, a mechanical behavioral protective supports and procedures may be substituted if deemed necessary by the licensed psychologist.

3. Following the initiation of a personal or mechanical behavioral protective supports and procedures, the registered nurse shall be notified and, at minimum, check the individual’s condition and the safety of the behavioral protective supports and procedures within 15 minutes and each hour thereafter (unless otherwise specified in the individual’s ILP with a clinically justifiable rationale).

4. When using personal or mechanical behavioral protective supports and procedures, the individual shall be released once he or she is determine to no longer be a danger to self or others and the protective supports and procedures shall not exceed 50 minutes. (NOTE: Exceptions to the 50 minute authorization time limit must be accompanied by a clinically justifiable rationale. For example, use of mittens for hand mouthing may not require re-authorization every 50 minutes depending on the plan for behavioral protective supports and procedures use and fading of behavioral protective supports and procedures use.) If, during attempts to release the individual from behavioral protective supports and procedures, the individual engages in behaviors necessitating behavioral protective supports and procedures (as defined in this policy), a new behavioral protective supports and procedures may be immediately implemented upon authorization. (NOTE: Every restrained limb shall be released from behavioral protective supports and procedures, examining it for bruising and skin tears, and exercising at least ten minutes every hour. The individual being subject to behavioral protective supports and procedures shall be provided an opportunity to eat, drink fluids and toilet as needed.)
5. Behavioral protective supports and procedures shall not be repeated more than 12 times consecutively or for more than a 12 hour period. Exceptions must be accompanied by a clinically justifiable rationale.

6. When chemical behavioral protective supports and procedures are used to control behavior, the following additional standards shall apply:

   a. Prior to implementation of an emergent chemical behavioral protective supports and procedures to control behavior, the licensed psychologist shall notify the physician of the circumstances that may require chemical behavioral protective supports and procedures. Following consultation from the licensed psychologist, the licensed physician may decide to prescribe a chemical behavioral protective supports and procedures. A chemical behavioral protective supports and procedures shall only be implemented as a final option.

   b. Chemical behavioral protective supports and procedures shall only be used in response to a physician’s order.

   c. A licensed physician or the physician’s authorized designee shall observe the person and evaluate his/her response to emergent chemical behavioral protective supports and procedures within 1 hour of the intervention.

   d. The physician shall establish a schedule for medical monitoring based on the ethics and standards of the medical profession. The monitoring is to include effects as well as adverse effects. At minimum, this monitoring shall include face-to-face monitoring by a staff person for a time period designated by the physician.

   e. Staff persons responsible for monitoring shall be provided detailed information to ensure effective monitoring. The physician shall direct medical staff to inform direct support staff of the potential side-effects of the medication prescribed for behavioral protective supports and procedures.

   f. Planned chemical behavioral protective supports and procedures to control behavior shall be reviewed by the IDT, at minimum, every 90 days to consider the individual’s response to chemical suppression and to consider treatment alternatives. This shall involve a review of the behavioral data, data concerning medication side-effects, progress towards long-term goals and other relevant factors.

7. Following each instance of behavioral protective supports and procedures, the licensed psychologist shall review essential data by the next working day. Essential data shall include, at minimum, antecedent events, topography of the behavior and consequences.

8. The IDT will review all instances of behavioral protective supports and procedures use at the monthly treatment team meeting. If three instances of behavioral protective supports and procedures are required within 30 days, the IDT will meet the next working day following the third instance. Each IDT review will be accompanied by written documentation within the individual’s record.
8. The frequency and use of behavioral protective supports and procedures shall be reviewed, at minimum, monthly by the agency’s Quality Enhancement Committee as part of the risk management process.

V. ORGANIZATIONAL PERFORMANCE EVALUATION

OCDD supports a service model that minimizes the need for behavioral protective supports and procedures and maximizes safety for individuals served. An essential component of this goal is to establish a policy for evaluating the effectiveness of procedures for reducing and/or eliminating protective supports and procedures at all levels of the current State system. This is the intent of the policy concerning performance evaluation.

A. For each episode of behavioral protective supports and procedures, the OCDD protective supports and procedures authorization and recording form shall be completed (see Attachment A). This document includes:

1. name of the individual;
2. identification number;
3. information clearly identifying the individual’s residence (e.g., agency, home at the agency, and other pertinent information);
4. identification of the type of protective supports and procedures used;
5. identification of the method of protective supports and procedures used;
   a. personal protective supports and procedures,
   b. mechanical protective supports and procedures,
   c. chemical protective supports and procedures
6. identification of staff persons involved in the protective supports and procedures;
7. time of the protective supports and procedures;
8. duration of the protective supports and procedures;
9. injuries occurring as a result of protective supports and procedures; and
10. documentation concerning accountability and policy implementation including:
   a. identification of the professional authorizing protective supports and procedures including times and the type and method of protective supports and procedures authorized;
   b. documentation of whether the protective supports and procedures was approved by the IDT and included in the Individual Support Plan;
   c. documentation as to whether the staff person(s) applying a behavioral or mechanical protective supports and procedures was qualified by training and current level of competency; and
   d. documentation concerning the monitoring and evaluation of each protective supports and
11. Documentation of each protective supports and procedures episode to include type and duration shall be kept in the individual’s record and a central database.

B. OCDD maintains a database that enables the organization to pose queries and follow trends concerning the following data:

1. The following frequency measures are not to include chemical protective supports and procedures and mechanical protective supports and procedures applied non-contingently (e.g., mittens, helmets and other devices applied prior to the presence of a specific behavior that is to be prevented). These frequency measures include:
   a. the number of episodes requiring behavioral protective supports and procedures per day, week, month and year;
   b. the number of episodes involving behavioral protective supports and procedures per individual, home, unit (if applicable) and agency;
   c. the number of individuals requiring medical protective supports and procedures per day, week, month and year;
   d. the number of individuals requiring medical protective supports and procedures per home and unit (if applicable);
   e. the number of times each type and method of protective supports and procedures (Section IV, A, 4-5) is used per day, week, month, and year;
   f. the number of each type and method of protective supports and procedures implemented per staff and per shift;

2. Other frequency measures include:
   a. the number of individual requiring the use of non-contingent mechanical protective supports and procedures per day, week, month, and year (e.g., mittens, helmets, and other devices applied prior to the presence of a specific behavior that is to be prevented);
   b. for unplanned usage of chemical protective supports and procedures, the number of orders for chemical protective supports and procedures per individual per day, week, month and year; and
   c. the number of individuals with planned chemical protective supports and procedures per day, week, month and year.
   d. the number of minor injuries, serious injuries, and deaths, if any, associated with protective supports and procedures.

3. Duration measures include for non-contingent mechanical protective supports and procedures (e.g., mittens, helmets, and devices applied prior to the presence of a specific behavior that is to be prevented), the average time of usage per individual per day, week, month, and year.

   [Note: When a mechanical protective supports and procedures is used contingent upon the immediate presence of a behavior(s), frequency data shall be collected, even if the protective
supports and procedures involves mittens, helmets or other devices associated with non-contingent applications). Duration data may also be collected, but to maintain consistency, these protective supports and procedures shall be counted with other contingent mechanical protective supports and procedures applications.]

C. At minimum, the following data trends shall be reviewed by OCDD’s Quality Steering Committee at least monthly:

1. the number of behavioral protective supports and procedures episodes per agency;
2. the number of medical protective supports and procedures per agency with the exception of preventive mechanical protective supports and procedures;
3. the duration of non-contingent mechanical protective supports and procedures (as described above) per agency;
4. the number of times each type of protective supports and procedures is used (i.e., physical, mechanical and chemical);
5. the number of minor injuries, serious injuries and deaths, if any, associated with protective supports and procedures.

D. Additional reviews or analyses may be required at the discretion of OCDD’s Executive Management Team and/or Quality Steering Committee.