

DEVELOPMENTAL DISABILITIES ADMINISTRATION

Olympia, Washington

TITLE:	RESTRICTIVE PROCEDURES: COMMUNITY	5.15
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Authority:	42 C.F.R. 441.301(c)(4)	<i>Home and Community-Based Settings</i>
	Title 71A RCW	<i>Developmental Disabilities</i>
	Chapter 71A.26 RCW	<i>Client Rights</i>
	Chapter 388-101D WAC	<i>Certified Community Residential Services and Supports</i>
	Chapter 388-825 WAC	<i>Developmental Disabilities Services</i>
	Chapter 388-850 WAC	<i>County Plan for Developmental Disabilities</i>
	42 C.F.R. 483.25	<i>Bed Rails</i>
	Chapter 388-829R WAC	<i>Overnight Planned Respite Services</i>
Reference:	DDA 5.06	<i>Client Rights</i>
	DDA 5.14	<i>Positive Behavior Support Principles</i>
	DDA 5.16	<i>Psychotropic Medications</i>
	DDA 5.17	<i>Physical Intervention Techniques</i>
	DDA 5.21	<i>Functional Assessments and Positive Behavior Support Plans</i>
	DDA 6.12	<i>Incident Management and Reporting Requirements for Residential Service Providers</i>

BACKGROUND

Clients receiving residential habilitation services have the right to services that are outlined in a person-centered-service plan (PCSP) that is directed and agreed to by the client. The PCSP addresses identified functional needs and provides for services commensurate with the identified level of need. Habilitative services support full access to the greater community so the client may benefit from and contribute to the community to the same degree as people who do not receive Home and Community-Based Services.

When a client's behavior presents a threat of injury to self or others, or threatens significant damage to the property of others, steps must be taken to protect the client, others, and property of others from harm. Supports and interventions as described in [DDA Policy 5.14](#), *Positive Behavior Support Principles*, and [DDA Policy 5.21](#), *Functional Assessments and Positive*

Behavior Support Plans, must be used to decrease the behaviors and eliminate the need for restrictive procedures. When positive behavior support alone is insufficient, temporary restrictions may be necessary. Many of the restrictions described in this policy represent a modification to the setting in which Home and Community-Based Services are provided. When modifications are suggested, they must meet an assessed functional need and the recommendation must be the result of a client-led person-centered planning process.

PURPOSE

This policy describes which restrictive procedures are allowed and which are prohibited, the circumstances under which allowed restrictive procedures may be used, the requirements that must be met before they may be used, and the requirements for documenting and monitoring their use. For clarification, procedures that are not restrictive and do not require a functional assessment (FA) or positive behavior support plan (PBSP) are also described.

SCOPE

This policy applies to the following DDA-contracted or certified residential service programs:

- Supported living
- Group homes
- Group training homes
- Alternative living
- Companion homes
- State-operated community residential programs
 - State-operated living alternatives for adults
 - Stabilization, assessment, and intervention facility
- Crisis diversion bed and support services
- DDA-funded employment and day programs and services provided by counties
- Overnight planned respite services

State laws and rules governing adult family homes and assisted living facilities take precedence over this policy. Certain physical interventions permitted under this policy with an FA and a PBSP are prohibited in assisted living facilities and adult family homes. Administrators of such facilities should refer to [Chapter 18.20 RCW](#) and [Chapter 70.129 RCW](#).

DEFINITIONS

Audio monitor means any type of device that can be used to remotely listen to a person or the sounds in an area around the device.

Aversive stimulation means the application of a stimulus that is unpleasant to the client, such as water mist to the face, unpleasant tastes applied directly to the mouth, noxious smells, applying

an electric shock, or causing pain. *This procedure is prohibited for providers in the scope of the policy.*

Chemical restraint means the administration of any drug to manage a client's behavior in a way that reduces the safety risk to the client or others, has the temporary effect of restricting the client's freedom of movement, and is:

- Used to discipline the client;
- Used for staff or provider convenience; or
- Not standard treatment for the client's medical or psychiatric condition. *Chemical restraint is a prohibited procedure.*

Corporal punishment means physical punishment of any kind. *Corporal punishment is prohibited.*

Emergency means an extreme hazard or an unanticipated, unpredicted action that puts the client or others at risk and jeopardizes the health and safety of the client or others (e.g., when a client is standing or sitting in the street or when a client is at immediate risk of danger from a fire).

Exclusionary time out means removing a client from the environment where positive reinforcement is available to an area where positive reinforcement is not available, after a client demonstrates a specific behavior, and the client is prevented from exiting the area. *Exclusionary time out is prohibited.*

Forced compliance means verbally or physically forcing a client to do something they do not want to do. *Forced compliance is prohibited.*

Locking a client alone in a room means egress is not possible. *Locking a client alone in a room is prohibited.*

Mechanical restraint means any device attached or adjacent to the client's body that they cannot easily remove that restricts freedom of movement or normal access to their body. "Mechanical restraint" does not include the use of devices, materials, or equipment that are medically authorized and used in a manner that is consistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under [Chapter 71A.12 RCW](#).

Medically necessary means healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Overcorrection means requiring a client to clean or fix the environment more than necessary to restore it to its original state, or to repeatedly practice the correct way to do something as a consequence for having done something wrong. *Overcorrection is prohibited.*

Physical or mechanical restraint in a prone position means the client is restrained while lying on their stomach. *Physical or mechanical restraint in a prone position is prohibited.*

Physical restraint means physically holding or restraining all or part of a client's body in a way that restricts the client's free movement. This does not include briefly holding, without undue force, a client to calm them, holding a client's hand to escort the client safely from one area to another, or using seatbelts for wheelchair safety.

Restraint in a supine position means the client is being restrained while lying on their back. *Physical restraint in a supine position is prohibited.*

Protection means supervision and supports that enable a client to function at the client's highest level that minimize or prevent injury or harm.

Restraint means any method used to limit a client's freedom of movement or immobilize the client. This includes using a device or garment (mechanical restraint), holding or bodily maneuver (physical restraint), drug (chemical restraint) or restriction of space (exclusionary time out) to physically control, subdue, or calm a client who exhibits behavior that presents a risk of harm to the client, others, or property.

Restrictive procedure means a procedure that restricts a client's freedom of movement, restricts access to client property, requires a client to do something which they do not want to do, or removes something the client owns or has earned.

Seclusion means locking a client alone in a room or using another mechanism, such as a Posey bed, that makes egress impossible. *Seclusion is prohibited.*

Target behavior means a behavior identified by the provider that needs to be modified or replaced.

Video monitor means any type of device that can be used to visually monitor a client or area. This includes standard video monitors and recording devices, closed-circuit monitors, cell phones with video capabilities, Wi-Fi cameras, and web-enabled cameras, such as those accessible through a computer.

POLICY

- A. Lesser restrictive supports and interventions must be used before implementing a restrictive procedure that may modify community-based settings, services, or access.

- B. A restrictive procedure may be used only for the purpose of protection. A restrictive procedure must not be used for the purpose of changing behavior in situations where no need for protection is present.
- C. Only the least restrictive procedure needed to adequately protect the client, others, or property may be used.
- D. A restrictive procedure must be terminated as soon as the need for protection is over.
- E. When a client's PBSP contains a restrictive procedure that may impact a housemate, efforts must be made to minimize the effect on the housemate. The provider must document in the housemate's plan how they will address the impact on the housemate and protect the rights of each client. Consent to the plan by the housemate and the housemate's legal representative must be reviewed and documented in the provider's client record annually.

F. **Non-Restrictive Procedures**

1. Teaching, Training, and Support Methods

The following procedures are not restrictive and an FA and PBSP are not required to use these procedures. The provider works as part of the person-centered planning team to meet the client's assessed needs. If the following procedures are used frequently, the provider should provide staff instructions for the use of these procedures in the individual instruction and support plan.

- a. Prompting by using verbal and physical cues or gestures and physical assistance.
- b. Simple correction by explaining or showing how to do something correctly, coaching, or guiding the client with or without physical assistance. Correction must be demonstrated in a respectful manner.
- c. Not attending to specific behaviors that are inappropriate.
- d. Offering or suggesting alternatives and discussing consequences of different behaviors.
- e. Setting up incentive programs using tokens or points with special motivators, such as money, CDs, or videos. Incentives must not be purchased using a client's funds.

- f. Teaching and encouraging a client to choose and purchase healthy, nutritional food.
- g. Canceling an activity because the client is agitated at the time of the event.
- h. Securing access to prescription medicines, over-the-counter medications, and hazardous and harmful chemicals such as laxatives, shampoo, cleaning products, and insecticides when made necessary by an assessed functional need.
- i. Physically blocking a client for protection without holding the client.
- j. Requiring a client to leave an area for protection, without physical coercion.
- k. Use of medical alert devices for client safety and health conditions such as seizures, falls, or dementia. The client may wear a medical alert device, such as a necklace or bracelet.
- l. Use of door alarms, window alarms, and video doorbells as part of a home security system is not a restrictive procedure when used to secure the home from outside actions.
- m. If elements of the home security system are used to address the client's functional needs because of dementia, poor traffic safety skills, becoming lost easily, or similar functional needs:
 - i. The case manager must meet with the client, people the client invites, and the provider to develop additions to the person-centered plan to address the assessed functional needs requiring the use of global positioning satellites (GPS) capable devices to know the client's location.
 - ii. The use of GPS enabled devices to enable the provider to know the client's location must be documented in the settings modification screen in CARE by the case manager and in the IISP by the provider.

Note: For a client approved to receive overnight planned respite services, the provider must document the use of security devices in the Individualized Respite Agreement and have consent from the

client, or the client's legal representative if they have one, before the start of services.

- n. Use of audio monitors for client health and safety.
 - i. A provider may use an audio monitor only if it is medically necessary for the client's health and safety (e.g., for a client who has frequent falls resulting in injury, clients with uncontrolled seizures). If a provider uses an audio monitor, the provider must:
 - A) Document why less invasive options – such as additional staffing, or installing call buttons, bed alarms, and motion sensors – are insufficient to meet the client's medical necessity;
 - B) Not use the device for staff convenience or to invade a client's privacy;
 - C) Inform the client and all people who may be captured by the monitoring and obtain consent for its use. Under [RCW 9.73.030](#), consent is considered obtained whenever one party has announced to all other parties engaged in the communication or conversation, in any reasonably effective manner (such as a notice), that such communication or conversation is about to be transmitted. Written consent from the client for whom the monitoring is put in place must be documented in the client's record; and

Note: [RCW 9.73.030](#) prohibits the intercepting and recording of private communication without first obtaining the consent of all participants in the communication.
 - D) Write a plan that includes the reason for use of the monitoring device and specific details about when the monitor will be turned on and off. This plan must be documented in the client's record.
 - ii. Providers must inform the client's case manager if use of an audio monitor is contemplated and provide the case manager a copy of the written plan.

- iii. The case manager must notify the field services administrator of the use of an audio monitor with the client.
- iv. The case manager must document use of an audio monitor in the settings modification screen in CARE and the provider must document use of the audio monitor in the IISP.
- o. Taking away a client's pet when the client is abusive or neglectful to the pet. Abusive means physical abuse or sexual abuse. Neglectful means failing to provide for the health and safety of the pet, including withholding routine and emergency veterinary care, vaccinations, failing to provide the pet with fresh water and food daily, and humane treatment.
 - i. If a client's pet is temporarily removed, the case manager must assemble a team including the client, people the client invites, and provider to develop additions to the person-centered service plan to address and document:
 - A) Instruction and support the client needs in the handling and proper care of the pet; and
 - B) The client's response to instruction and ability to follow pet care guidelines in the agreed upon plan.
 - ii. The provider must:
 - A) Document in the IISP the client's instruction and support needs for handling and proper care of the pet; and
 - B) Report incidents of client mistreatment of an animal or pet according to incident reporting procedures, which includes reporting to DDA.
 - iii. Physical abuse of a pet may be grounds for permanent removal of the pet and may result in prohibition of acquisition of another pet by the client. This determination will be made jointly by the client, decision maker, and DDA in consultation with the residential provider. If it is determined that the client cannot support a pet and must not obtain another, the case manager must document this settings modification in the settings modification screen in CARE.

- p. If the use of cellular phones and other devices with GPS capabilities for the purpose of tracking the client are required to meet the client's assessed needs:
 - i. The case manager must meet with the client, people the client invites, and the provider to develop additions to the person-centered plan to address the assessed functional needs requiring the use of global positioning satellites (GPS) capable devices to know the client's location.
 - ii. The use of GPS-enabled devices that enable the provider to know the client's location must be documented in the settings modification screen in CARE by the case manager and in the IISP by the provider.
- q. Requiring a client to use a seatbelt when riding in a motor vehicle.

2. Money Management and Support

An important support many people need is help managing financial resources. The client must be involved and lead in managing their financial resources based on their abilities and assessed functional needs. The agreed upon financial plan must provide for the client's necessities, financial obligations, and honor the client's stated preferences. Ways to support the client include:

- a. Developing a budget consistent with the client's interests and financial resources;
- b. Monitoring weekly expenditures to ensure the client does not overspend;
- c. Paying rent and bills on time;
- d. Buying food;
- e. Purchasing clothing and other items the client wants; and
- f. Budgeting money for leisure activities.

3. Medical Devices with Known Safety Risks

- a. [WAC 388-101D-0155](#) describes requirements for the use of medical devices, including steps providers must take before using medical devices with known safety risks with a client.

- b. Bedside rails are permitted when medically necessary for the client's health and safety.
- c. Before installing a bedrail, the provider must:
 - i. Assess the client for risk of entrapment from bed rails;
 - ii. Review the risks and benefits of bed rails with the client or client's representative and obtain informed consent; and
 - iii. Ensure that the bed's dimensions are appropriate for the client's size and weight.
- d. The provider must provide staff with written instructions for the use of bedside rails. Instructions must:
 - i. Require the bed rails be installed and maintained according to the manufacturer's recommendations and specifications;
 - ii. Require staff to check that the mattress fits tightly against the side rail;
 - iii. For a client unable to reposition themselves, require staff to assist the client with position changes no less than once every two hours during waking hours (and at night if the prescriber requests);
 - iv. State the frequency of bed checks and require staff to check for safety and well-being during awake hours at a higher frequency than repositioning; and
 - v. Prohibit the use of bedside rails for staff convenience for restraining a client unnecessarily.

G. Restrictive Procedures Permitted Without an Exception to Policy (ETP)

- 1. Clients have the right to be free from unnecessary restrictions and restraints. Before implementing restrictive procedures:
 - a. The provider must document lesser restrictive interventions and supports that have been tried and reasons each intervention did not meet the client's assessed functional need; and
 - b. The case manager must document:

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- i. A person-centered planning meeting with the client, people the client invites, and the provider;
 - ii. The agreed upon plan; and
 - iii. In the settings modification screen in CARE, any restrictive procedure from this section that constitutes a settings modification.
 2. If a provider uses a restrictive procedure, its use must be addressed in the client's FA and PBSP. The FA and PBSP must:
 - a. Establish the need for the restrictive procedure;
 - b. Outline behavioral criteria that will indicate a restrictive procedure is no longer necessary; and
 - c. Include the teaching supports and steps involved in accomplishing the goal or criteria that indicates the use of a restrictive procedure is no longer necessary.
 3. Restrictive procedures allowed without an ETP are those that interrupt or prevent behaviors that:
 - a. Are dangerous or harmful to the client or others;
 - b. Cause significant emotional or psychological stress to others; or
 - c. Result in significant damage to the property of others.
 4. The following restrictive procedures are allowed without an ETP:
 - a. Requiring a client to leave an area with physical coercion (i.e., physically holding and moving the client with force) for protection of the client, others, or property of others.
 - b. Using door or window alarms to monitor a client who presents a risk to others, such as being sexually or physically assaultive. The case manager must document in the settings modifications screen in CARE if a door or window alarm is used to monitor a client.
 - c. Necessary supervision to prevent dangerous behavior.

- d. Taking away or restricting access to items used as weapons when the client has a documented history of making threats or inflicting harm with those items, such as knives, matches, or lighters.
- e. Removing client property being used to injure oneself, others, or property. Removing property belonging to others is not a restrictive procedure.
- f. Physical restraint to prevent the free movement of part or all of the client's body with the exception of seated restraints, which require an ETP, and prohibited restraints (in a prone or supine position i.e., lying on the stomach or back, respectively). See also [DDA 5.17](#), *Physical Intervention Techniques*. Use of physical restraints must be documented in the settings modifications screen in CARE.

Note: Restrictive procedures in subsections (a) through (f) above require the PBSP to document the teaching plan emphasizing skills that will make the use of the restrictive procedure no longer necessary and the criteria for the reduction and elimination of the restriction.

- g. Mechanical restraint used to limit the client's free movement or prevent the client from self-injury when the client cannot independently remove the device, such as a helmet, arm splints, seatbelts used outside of a motor vehicle, etc. See also [WAC 388-101D-0155](#). Assessment of medical necessity must include:
 - i. Documentation of the need for use of the device;
 - ii. Health care professional's written documentation for the use of the device to include when device can be applied and must be removed;
 - iii. A plan to reduce or eliminate the use of the device if used to modify a target behavior in the positive behavior support plan; and
 - iv. Documentation of use of mechanical restraints in the settings modifications screen in the CARE assessment by the case manager.

H. Restrictive Procedures Permitted Only by Exception to Policy (ETP)

- 1. Each of the restrictive procedures in this section requires the case manager to initiate a person-centered planning process with the client, people the client invites, and providers to address the assessed functional needs and develop an agreed upon plan.

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2. The case manager must document each exception to policy for the use of restrictive procedures in the settings modification screen in CARE.
 3. The following restrictive procedures may be used only when less intrusive procedures have failed to protect the client, others, or property. These procedures must not be used for staff convenience or as a punishment. Use of these procedures requires a FA, PBSP, and an ETP.
 4. Approval at the Deputy Assistant Secretary Level
The following restrictive procedures require the prior written approval of the deputy assistant secretary:
 - a. Not allowing a client to attend activities, at home or in the community, as a disciplinary consequence (e.g., not allowing the client to watch TV because they did not do the dishes; not allowing the client to go bowling because they hit a client the day before).

Note: If a client is upset immediately before an activity, or there is evidence that the client is likely to engage in severe target behaviors at an activity, the activity may be delayed, postponed, or rescheduled. No ETP is required.

 - b. Removing a client's property as a disciplinary consequence when the risk of damage to property or injury to a client or others is not an issue. For example, removing the client's television after the client has been accessing material restricted by the community protection program therapist and treatment team despite numerous efforts to help the client follow treatment program restrictions.
 - c. Use of video monitors for medical necessity for more than six months. See Section (5)(i) below for complete requirements.
 5. Approval at the Regional Administrator Level
The following restrictive procedures require the prior written approval of the DDA regional administrator.
 - a. Controlling food consumption, including but not limited to locking the kitchen, refrigerator, or cabinets. Any request to limit or lock up a client's food for health reasons should address how they will gain access to food and liquids and include a plan to address the health condition. Additional information may be found in [DDA Food Management and Health Promotion Strategies](#). Such restrictions may be considered when:
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- i. A long-term threat exists to the client's health, as determined in writing by a physician;
- ii. A short-term threat exists, such as eating raw meat or uncontrolled water intake; or
- iii. It is necessary for assisting the client to live within their budget.

Note: If the client understands and complies with their dietary restrictions (i.e., does not exhibit any target behaviors in response) and the client's food and kitchen does not need to be secured, an FA and PBSP are not required. For example, if a client diagnosed with diabetes is on a special diet, willingly complies with the diet, and it is not necessary to lock up the kitchen or the food, an FA and PBSP are not required because the client chooses to follow the restrictive diet.

Note: For a client approved to receive overnight planned respite services, the provider must obtain approval from the DDA headquarters respite coordinator rather than the DDA regional administrator for any request to limit or lock up a client's food or food intended for the client.

- b. Requiring a client to wear any electronic monitoring device on their body to monitor the client's behavior. The client and their legal representative must give consent if there is no court order.
- c. Regulating or controlling a client's money in a manner the client or the client's legal representative object to. See also Policy Section (F)(2) regarding money management.
- d. The use of locks on doors, gates, and fences that prevent independent egress from the residence or yard. Keyed locks where someone must use a key from inside to exit must be avoided whenever possible. If a keyed lock must be used, the ETP must include a safety plan for its use in case of an emergency.

Note: For a client approved to receive overnight planned respite services, the provider must document the use of any device used on a door, gate, or fence that prevents independent egress from the residence or yard in the Individualized Respite Agreement and have consent from the client, or the client's legal representative if

they have one, before the start of services to identify the plan in an emergency.

- e. The use of seat belt locks or door lock safety features in vehicles to transport clients whose target behaviors, such as unlocking regular seat belts and opening vehicle doors while the vehicle is in operation or impedes safe travel.
- f. Restrictions on access to media that is violent or sexually explicit, such as pornography, actual or depicted violence in mediums such as television, video games, other recorded media, and print.*
- g. Restricting access to alcohol.*
- h. Routine search (i.e., a planned or scheduled search) of a client or their home and possessions. Without a court order or as a condition of community supervision, the client and their legal representative must consent to the procedure. A legitimate and significant reason to conduct the search must exist.*
- i. Using video monitors for client's health and safety.
 - i. All people have the right to privacy. The use of a video monitor in a client's home or bedroom is extremely intrusive. For this reason, there must be tight controls around the use of video monitors and ongoing assessment of their continued use. Refer to the Definitions Section of this policy regarding video monitors.
 - ii. Under no circumstances may a video monitor be used for staff convenience or to purposely invade a person's privacy. Video recording for monitoring purposes is not permitted.

* An ETP is not required when the restriction is included in a community protection program participant's professional treatment plan and must be related to reason the participant was made eligible for participation in the program. The case manager must document each restriction in the professional's treatment plan in CARE.

If the restriction is not directly related to the assessed need causing the client to be eligible for the community protection program, the provider must initiate the exception to policy for restrictive procedures process and the case manager must documented each restriction in the settings modification screen in CARE.

- iii. A provider may use video monitors if medically necessary for the client's health and safety and if all of the following requirements are met.
 - A) There is documentation that the client's interdisciplinary team, including the case manager and residential services staff, has explored other less invasive options, such as additional staffing, installing call buttons, bed alarms, or motion sensors, before requesting to use a video monitor.
 - B) There is a current physician's order that clearly states the medical necessity for the client and anticipated duration of monitor use.
 - C) Any client who may be monitored, and their legal representative and staff must be aware of the monitor and give consent for its use. Consent is considered obtained whenever one party has announced to all other parties engaged in the communication or conversation, in any reasonably effective manner (such as a notice), that such communication or conversation is about to be transmitted. Written consent for the client for whom the monitoring is put in place must be documented in the client's record.
 - D) Protected health information shared using electronic devices must comply with the Health Insurance and Portability Accountability Act requirements.
 - E) There is a written plan that gives direction to all residential staff regarding:
 - 1) When the monitor will be turned on and off;
 - 2) Privacy issues;
 - 3) How to respond when the client turns off the monitor or requests that the monitor be turned off;
 - 4) Documentation requirements; and
 - 5) Specific instruction for staff who are responsible for viewing the monitor.

- F) There is an approved ETP.
 - 1) If the monitor will be used for six months or less, the regional administrator is the approving authority; or
 - 2) If it is anticipated that the monitor will be used for more than six months, the deputy assistant secretary is the approving authority.
- G) Residential staff must document the use of the monitor, including duration and name of staff, on a daily basis. This data must be included in the client's record.
- j. Restricting a client's right to choose with whom the client wants to associate, visit, communicate; limiting the client's right to access public places, areas, or venues where certain populations or groups interact; or limiting the client's use of means of communication (e.g., limiting 900 calls or telephone service, supervising telephone usage to monitor behavior, etc.) requires the following for the approval of an ETP.*

If a client is not enrolled in the Community Protection Program does not have a legal guardian:

- i. The client may voluntarily consent to restrictions limiting their access to people, classes of people, public places, events, or media promoting social interaction or communication as an agreed upon plan from a person-centered planning process.
- ii. If a client does not voluntarily consent to restrictions limiting their access to people, classes of people, public places, events, or media promoting social interaction or communication, the provider should consult the client's case manager and case manager supervisor.

* An ETP is not required when the restriction is included in a community protection program participant's professional treatment plan and is related to reason the participant was made eligible for participation in the program. The case manager must document in CARE each restriction in the professional's treatment plan.

If the restriction is not directly related to the assessed need causing the client to be eligible for the community protection program, the provider must initiate the exception to policy for restrictive procedures process and the case manager must document each restriction in the settings modification screen in CARE.

- iii. For a client who has an appointed guardian, the restriction may only be approved with a guardianship court order authorizing the guardian to limit the client's access to people, classes of people, public places, events, or various media promoting social interaction or communication as an agreed upon plan from a person-center planning process. For more information see RCW [11.130.335](#).
- k. The following restrictive physical interventions may be approved at the regional administrator level if used as part of an approved physical intervention system or curricula:
 - i. The client is seated on furniture and physically restrained by people sitting on either side.
 - ii. The client is seated on the floor and being physically restrained by one or more people.
- l. Requiring the client to wear a garment or modified clothing that the client is unable to remove and is intended to restrict the client's normal freedom of movement or limit access to their body.

I. **Prohibited Procedures**

The following restrictive procedures are not permitted under any circumstances and DDA will not grant an ETP for their use:

1. Restraint chairs;
2. Restraint boards;
3. Exclusionary time out;
4. Corporal or physical punishment;
5. Forced compliance, including exercise, when it is not for protection;
6. Locking a client alone in a room;
7. Overcorrection;
8. Physical or mechanical restraint in a prone position (i.e., the client is lying on their stomach);
9. Physical or mechanical restraint in a supine position (i.e., the client is lying on their back);
10. Removing, withholding, or taking away money, tokens, points, or activities that a client has previously earned;
11. Requiring a client to re-earn money, tokens, points, activities, or items purchased previously;
12. Withholding or modifying food as a consequence for behavior (e.g., withholding dessert because the client was aggressive);

13. Chemical restraint;
14. A posey bed, also known as a tent bed, or enclosed bed system; and
15. Aversive stimulation.

J. Treatment of Sexual Deviancy

For clients with a history of sexual assault or inappropriate sexual behaviors, or clients who have committed illegal acts of a sexual nature, the client's individualized treatment plan may involve restrictions that affect the client's home or work setting. In these cases, the certified Sex Offender Treatment Provider (C-SOTP), or an Affiliate SOTP (A-SOTP) working under the supervision of a C-SOTP, must clearly explain how each restriction affecting the client's home or work environment is directly related to the reason the client is eligible for participation in the community protection program.

An Exception to Policy for Restrictive Procedures may be approved only when:

1. Documentation demonstrates other less restrictive procedures and treatment modalities have been tried, data demonstrate lesser restrictive procedures and treatment modalities were not effective, and reasons for lesser restrictive procedures are clearly supported by documented data.
2. The client must consent to the procedures as part of their therapeutic treatment. For specific requirements, refer to [DDA Policy 15.02](#), *Community Protection Program Services*, and [DDA Policy 15.04](#), *Standards for Community Protection Residential Services*.
3. Aversive stimulation is permitted for treatment of sexual deviancy if a C-SOTP or A-SOTP conducts the treatment and client's informed consent and an ETP has been obtained. It is the therapist's responsibility to request the ETP.

K. Court-Ordered Restrictions

1. Least restrictive alternatives (LRA) are court-ordered restrictions that a client agrees to meet as a condition of release from custody. Upon the client's request, DDA or a provider may assist the client in meeting court-imposed restrictive conditions if:
 - a. The case manager documents the request for support in CARE; and
 - b. The support provided is the result of a person-centered planning process and is documented in a professional treatment plan or PBSP.

2. A provider must only initiate restrictive procedures that are permitted by this policy. Additionally, all requirements of this policy must be met, including those relating to ETPs.
3. If a client has a restraining order or court order directing no contact with another person or location, staff may assist the client in adhering to the restraining order. No ETP is required.
4. If a court-ordered restriction also applies as a health and safety related need that requires a settings modification, the case manager must document the restriction in the modifications screen in CARE.

L. Emergency Use of Restrictive Procedures

1. Emergencies may occur where a client's behavior presents an immediate risk to the health and safety of the client or others, or a threat to property of others. In such situations, restrictive procedures permitted in this policy may be used for protective purposes. However, the least restrictive procedure that will provide adequate protection must be used and terminated as soon as the need for protection is over.
2. No procedure that requires an ETP may be used in an emergency other than those described in subsection (5) of this section.
3. For each incident leading to the use of an emergency restrictive procedure, the provider must submit an incident report to the case manager in accordance with procedures for reporting incidents under DDA Policy 6.12, *Incident Management and Reporting Requirements for Residential Service Providers*.
4. If a physical restraint or restrictive procedure requiring an FA, PBSP, or an exception to policy is used on an emergency basis three times in six months, the provider must follow the procedures outlined in [DDA Policy 5.21](#), *Functional Assessments and Positive Behavior Support Plans*.
5. For a client who poses an immediate danger to self or others, it is acceptable to initiate the following procedures or interventions immediately without an FA, PBSP, or ETP if there is reasonable justification:
 - a. Necessary supervision and related activities under Policy Section (H)(4)(c); or
 - b. Temporary access restriction under Policy Section (H)(4)(d-f).

Once the provider notifies DDA of this action, the regional administrator or designee must subsequently approve or disapprove in no more than three working days. Approval must be written with a brief statement of the problem and reason for the restriction. A written FA, PBSP, and ETP request, if necessary, must be completed in no more than 60 days.

PROCEDURES

- A. When use of a restrictive procedure is planned, the provider must communicate this to the case manager. Such communication must be made in writing. Before implementing restrictive procedures, the case manager must initiate a person-centered planning meeting with the client and the client's legal representative, people the client invites, and the provider. The meeting must address the assessed functional need and review the following at a minimum:
1. The specific restrictive procedures to be used;
 2. The perceived risks of both the client's target behavior and the restrictive procedures;
 3. Data and reasons justifying the use of the restrictive procedures;
 4. The reasons why each less restrictive procedure was not effective,
 5. The client's perspective and opinion on the proposed restrictive procedure, and
 6. The agreed upon plan to address the assessed need.
- B. **Required Documentation for Use of Restrictive Procedures**
1. The provider must submit a functional assessment that defines target behaviors the restrictive procedure intends to avoid, modify, or prevent.
 2. The provider must implement a PBSP designed to reduce or eliminate target behaviors.
 3. The PBSP must include:
 - a. A description of the restrictive procedure that will be used, when and how it will be used, and clear criteria for termination of its use.
 - b. A plan for recording data on the use of the procedure and its effect (each use of the restrictive procedure must be documented). The plan must

specify the type and frequency of data collection as outlined [DDA Policy 5.21](#), *Functional Assessment and Positive Behavior Support Plan*.

- c. A clear definition of the replacement behavior and how client use of replacement behavior is to be documented.
 - d. Goals for increased use of replacement behaviors and decreased use of target behaviors developed through the person-centered planning process will use to evaluate the effectiveness of the PBSP and determine when the restrictive procedure will be terminated from the PBSP, professional treatment plan, and person-centered plan.
4. For a client participating in the community protection program who has ongoing restrictions, the client's treatment plan must:
- a. Indicate that the restrictions are ongoing; and
 - b. Clearly state behaviorally defined criteria justifying the termination of the restriction.
5. Community protection program providers are exempt from documenting each use of an approved ongoing restriction; but providers must document each occurrence of replacement behaviors and provide that data for evaluation and review in meeting a restriction's termination criteria.

C. **Approval Process**

1. Before using a restrictive procedure, the proposed PBSP must be approved as follows.
- a. All PBSPs involving restrictive procedures require the written approval of:
 - i. The provider administrator or staff who have designated approval authority; and
 - ii. The client or the client's legal representative. The client's approval should be sought to the extent they understand what is being proposed.
 - b. PBSPs that require an ETP or involve physical or mechanical restraints require written approval by the client or the client's legal representative. The client's approval should be sought to the extent they understand what is being proposed.

- c. Approval must be documented on a form that lists the risks of the target behavior and the risks of the restrictive procedure, explains why less restrictive procedures are not recommended, and indicates alternatives to the recommendation. Space must be provided for the client and their legal representative to write comments and their opinions regarding the plan. See [DSHS 15-385](#), *Consent for Use of Restrictive Procedures Requiring an ETP*.
2. If the client or the client's legal representative disagree with any part of the proposed intervention strategies in the PBSP, the provider must consult with the case manager.

D. Monitoring Physical or Mechanical Restraint Procedures

1. Clients being restrained must be observed continuously to ensure the risks to the client's health and safety are minimized.
2. Whenever possible, a separate staff member not involved in restraining the client should observe the procedure.
3. Time in and out of restraint must be recorded.
4. Documentation must include a description of:
 - a. Events immediately preceding the behavior that precipitated the use of restraint;
 - b. Type of restraint or intervention;
 - c. Duration of the restraint;
 - d. The client's reaction to the intervention, including physical and mental state upon release from restraint;
 - e. The staff involved in implementing the intervention; and
 - f. Injuries sustained by anyone during the intervention.

E. Incident Reports

1. An incident report must be filed if:

- a. An injury requiring first aid or medical care is sustained by any client during implementation of a restrictive procedure or intervention;
 - b. A restrictive procedure is implemented under emergency guidelines; or
 - c. A client's animal or pet is abused or neglected. See Policy Section (F)(1)(o).
2. Incident reports must be submitted:
 - a. For employment and day programs according to [DDA Policy 6.08](#), *Mandatory Reporting Requirements for Employment and Day Services Providers*.
 - b. For all other providers in the scope of this policy, according to DDA Policy 6.12, *Incident Management and Reporting Requirements for Residential Services Providers*.

F. Data Monitoring of Restrictive Procedures

1. Program staff responsible for PBSPs must document review of the data at least every 30 days when the agreed upon plan does not designate a tighter time frame.
2. If the PBSP data indicates a target behavior is not decreasing or a replacement behavior is not increasing after 30 days but not for a period longer than 90 days, program staff responsible for the PBSP must review the plan and its implementation. If necessary, program staff responsible for the PBSP must revise the plan and the PBSP must be reviewed by the person-centered planning team.
3. At least annually, the person-centered planning team must review the plan and determine if the use of restrictive procedures continues to be needed and document in an agreed upon plan. That agreed upon plan, PBSP, and supporting data are presented to the approving authorities and the approving authority must review and approve restrictive procedures that require ETPs or involve physical or mechanical restraint. Documentation required in sections B of this section must be attached to the ETP request. The case manager must document each restriction in the settings modification screen in CARE.

EXCEPTIONS

- A. The facility, provider, or treatment professional requesting an ETP must use [DSHS 02-556](#), *Request for Exception to Policy (ETP) for Use of Restrictive Procedures*, and send the completed form with all its attachments to the case manager. A signed consent form

must accompany the request; use [DSHS 15-385](#), *Consent for Use of Restrictive Procedures Requiring an ETP*.

- B. Upon receipt of the ETP request packet, the case manager will initiate the restrictive procedures ETP request in the comprehensive reporting and assessment evaluation (CARE) application as follows:
1. Choose the ETR/ETP Category – Restrictive Procedures.
 2. Choose ETR/ETP Type – Restrictive Procedures.
 3. Choose Related Assessment.
 4. Choose Date Range: Custom or Plan Period, as appropriate.
 5. Enter Request Description:
 - a. Describe the behaviors for which the restrictive procedure ETP is being requested;
 - b. Describe in one or two sentences the restrictive procedure ETP being requested;
 - c. Type the following: “Refer to request packet in file dated _____.”
 6. Enter Justification for Request: “See request packet.”
 7. Enter Alternatives Explored: “See request packet.”
 8. Process to next level of review or approval based on the regional process.
 9. Print copy of ETP and attach to request packet for reviewer or approver.
 10. Document each restriction in the settings modification screen in CARE.
- C. ETPs for restrictive procedures described in Policy Section H, must be reviewed and approved or denied in writing by the regional administrator no more than 15 calendar days after receipt of the request and required documentation.
- D. ETPs for use of restrictive procedures that require approval at the deputy assistant secretary level must be submitted to and approved by the deputy assistant secretary before implementation.

- E. Any other exception to this policy must have the prior written approval of the deputy assistant secretary or designee.

SUPERSESSSION

DDA Policy 5.15, *Restrictive Procedures*
Issued July 1, 2021

Approved: /s/ Shannon Manion
Deputy Assistant Secretary
Developmental Disabilities Administration

Date: July 1, 2023