

Behavior Specialist Manual

2010

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Appendix Contents

DHS 4588 Functional Assessment/Behavior Support Plan (FA/BSP) , blank

DHS 4588 FA/BSP - Adding Additional “Behavior Sections” directions

DHS 4588 FA/BSP content example

DHS 4588 Good Day Plan example

DHS 4588 Interaction Guideline example

DHS 4515 Client Monthly Summary Report (Excel spreadsheet) linking data

Lifting and Positioning training

DHS 4562 Employee Instruction Record

Two-year Cumulative Training Record

Manual purpose

This manual is meant to be utilized as an informational guide for Behavioral Specialists in an effort to increase their initial and on-going understanding of their specific job duties and expectations. The purpose is two fold:

1. To collect and integrate all SOCP/DHS guidelines, policies and procedures, ISP Manual instructions and applicable Oregon Administrative Rules (OARs) in an easy-to-use manual to be utilized by the Behavioral Specialists in their work endeavors and;
2. To provide real-time examples of the expected and required job duties of the Behavioral Specialists.

This Manual is considered a “living document.” As such, it is subject to revision based on changes to agency policy/procedures and guidelines, OARs, and ISP instructions. In an effort to maintain the efficacy of this manual, it will be revised accordingly. These revisions will be documented in the manual and re-distributed to each Behavioral Specialist as needed. This will be done via email and/or fax.

The development of this manual was guided by the collaborative input and efforts of the Behavior Specialists, as well as by the following documents: Oregon’s Individual Support Plan System Instruction Manual (September 2009) www.otac.org

OARs 411-325-0340 and 411-325-0350:
http://www.dhs.state.or.us/policy/spd/rules/411_325.pdf

IR 4595

[Behavioral Specialist Position Description \(2005\)](#)

State Operated Community Program (SOCP) policies/procedures/guidelines:
<http://www.dhs.state.or.us/spd/tools/dd/socp/policy.html>

[DHS 4595G: Incident Report Guidelines](#)

[DHS 4622: Guidelines for Internal Client Moves](#)

[SOCP Overtime Manual](#)

IR 4595A	IR 4595B	IR 4595C	IR 4595D

Individual Support Plan overview

An **Individual Support Plan (ISP)** is an agreement made between an individual receiving services and the team of people supporting that individual. A well-crafted ISP will do four key things well:

1. Describe what is **important to** the person receiving services
2. Describe what is **important for** the person receiving services
3. Explain the **balance of** and any conflicts between what is important to and what is important for the person.
4. Document commitments from service providers and other to support the person towards their goals.

This planning system requires that all providers work in partnership to create one plan that documents the supports from providers and records perspectives and information from all team members. These requirements are for children and adult services as indicated by Oregon Developmental Disabilities Services (ODDS.)

A core responsibility for ISP teams is to support the individual in directing his/her own planning. Throughout the planning process the person has the opportunity to lead and/or participate in the activities.

The ISP process can be broken down into five basic steps:

STEP 1: Gather person centered information about the individual. This information comes from the perspective of the individual as well as those that know and care about the person and is documented on the **Personal Focus Worksheet (PFW)**. The PFW is the tool to write the information gathered and create a picture of who the person is.

STEP 2: Identify risks and align supports. **The Risk Tracking Record (RTR)** is used to identify serious and significant risks that are present in the person's life. Once risks are identified, Support Documents, or written instructions, are developed and implemented to prevent and/or minimize the risks and are reviewed and updated when needed. The RTR is created or reviewed at a Pre-Meeting.

STEP 3: Participants compile information gathered on the PFW, complete/update the RTR, draft the **Individual Support Plan (ISP) meeting Agenda**, and draft the first two pages of the ISP. This occurs during the Pre-Meeting.

STEP 4: ISP meeting. During the meeting, the ISP team plans with the individual and together create **Action Plans** to address issues and make commitments to support the individual in his/her life. This is documented on the **Individual Support Plan (ISP)**.

STEP 5: Train all staff who work directly with the individual on the contents of the ISP and Support Documents. Team members must ensure that the ISP and Support Documents are kept current throughout the year and that all ISP team members have a consistent plan to support the person. **Action Plans** must be completed by the responsible parties. **Change Forms** must be used to document updates and notify ISP team members when there are changes.

The Personal Focus Worksheet (PFW) and behavioral supports

Overview: The first step in preparing for an **Individual Support Plan (ISP)** is to listen to the person to find out what is important to him/her, what is currently going well in his/her life and what things need to change. This includes listening to the person and the people closest to him/her. It is a thoughtful, respectful process and it takes time. This person centered information is gathered and written on a **Personal Focus Worksheet (PFW.)**

BVS2: The **PFW** is completed by the BVS1 (45 days prior to an Individual's ISP) and used by the Behavioral Specialist in the following manner:

First step in identifying who the person is and what **NEEDS, PREFERENCES, AND RELATIONSHIPS**, either impact, direct, or motivate an individual's behaviors (both positive and negative).



If the team believes that an incentive plan would be appropriate for an individual (See BSP section), remember that whatever is listed as "Most Important" for an individual on their PFW, **cannot** be utilized as the incentive. For example, if what is most important to an individual is watching "Friends," then an incentive program **cannot** be structured as such: Bob will be able to watch "Friends" if he has not engaged in any dangerous behaviors for the entire shift.

The Risk Tracking Record (RTR) and behavioral supports

Overview: The **Risk Tracking Record (RTR)** is a document that identifies serious and significant risks that are present for the individual receiving services. It serves as a historical record for certain issues as well. Once it has been completed, it is reviewed annually and updated any time a risk changes for the person.

The RTR consists of pages with questions that look at serious and significant risks. Questions are grouped into three basic sections: Health/Medical, Safety/Financial, and Behavior/Mental Health.

Each question is designed to identify a specific risk that is commonly experienced by people receiving comprehensive services. Each section also includes questions that permit those completing the RTR to name risks that were not identified by the other questions in that section.

BVS2: The RTR is completed by the ISP team (Site Managers, Program Managers, Case Managers, the Individual, BVS1 and 2—45 days prior to an individual's ISP).

The BVS 2 is responsible for completing #50-67. This entails the following:

1. Working with the team to determine if particular risks are present for an individual based off of client/staff observations/interviews, and/or other data review;
2. Completing #50-67;

3. Providing the definition and any pertinent details of the identified behavior in the Notes section for any answer marked “Yes” or “History.”
 - For all risks marked “yes,” the BVS2 will want to identify the definition of that behavior. For example, if an individual has an identified risk of “Physical Aggression,” the notes section would read: #52. Physical Aggression: Hitting, kicking, spitting at others.
 - For all risks marked “history,” the BVS2 will want to identify the historical behavior, as well as its most recent occurrence. For example, if an individual has an identified historical risk of “Leaves Supervised Settings,” the notes section would read: #55. Leaves Supervised Settings: Client has a history of Leaving Supervised Settings, however there is only one documented incident of this behavior. This incident occurred on 5/1/00, in which the client eloped from the home’s locked gates.

Determining when a behavior is a risk

BVS2: The following factors must be considered in determining whether or not a particular behavior should be marked “YES” on the RTR:

Does the behavior interfere/threaten the following OAR 411-325-0430 (3)(c)?:

1. Community or Social Participation
2. Skill Acquisition or other activities
3. Safety of others or infringes on rights of others
4. Is at risk to the health or safety of self.

Intent/function: Take for example, two clients, Joe and Mary. Joe has been observed collecting small insects and attempting to keep them as pets in jars (where they typically die). In addition, Joe will often hold onto small animals (e.g. cats) too hard and refuse to let go. Mary has been observed throwing rocks at dogs and targeting the house cat (e.g. running after, attempting to kick).

Given only this information, it would appear that Mary is at risk for “Cruelty to Animals,” as her intent/function is to actually harm particular animals and/or express her anger, whereas Joe would not be at this risk, as his intent is more of a function of curiosity/desire to have an animal.

Scope of the behavior: Take again, two clients Joe and Mary. When talking with other individuals, Mary often gets very close to people’s faces. She remains calm and appropriate in her conversations. When talking with other individuals, Joe will also get very close to people’s faces, however he will also use this proximity in an attempt to fondle others.

Given only this information, it would appear that Joe is at risk for “Undesirable Sexual Behavior,” as he is not only violating people’s personal space (i.e. talking in their faces), but he is attempting to use this proximity for sexual gratification. In contrast, though Mary may be violating people’s personal space, and this could be considered “Undesirable Social Behavior,” the severity/depth is fairly insignificant. Mary’s behavior is more of a lack of social understanding that could be better addressed through coaching and modeling.

Is it addressed by other support documents (e.g. Financial Plans, Aspiration Protocols, Safety Plans)?: Mary has been observed eating her food very quickly—to

such an extent that she will often choke or cough up her food. Such a behavior, though dangerous is more effectively addressed by an Aspiration Protocol.



If the team believes that certain health/medical behaviors (e.g. choking, fainting, extreme food/liquid seeking, not receiving medical care) may be influenced by a behavioral issues, it should be addressed in the Blended Plan, outlining how to reduce the risk through environmental changes and/or staff supports. *This does not necessarily mean that these behaviors need to be “tracked” behaviors.*

The ISP Manual indicates that risks marked “Yes” signifies that a “person has engaged in the identified behavior within the last year or a Support Document has been in place and is working to prevent identified behavior during the past five years”.

If the person has a history of engaging in the identified behavior, but it is not a current problem, check “History.”

A behavior can only be marked as “History” if the team feels that it is no longer a **risk** and supports are no longer needed. If supports are needed, then the RTR answer **must** remain “YES.” This ensures that the team is aware of the risk that exists and that staff receive training on the current support document(s) that describe how to address the risk.

Determining what to label a behavior

BVS2: Oregon Technical Assistance Corporation (OTAC) has provided a list of behavior labels that **must** be utilized for categorizing an individual’s behaviors of concern. For example, an individual may engage in “hitting” behavior. According to the RTR, this would be labeled as, “Physical Aggression.” The definition of this behavior for a particular individual would then be: “hitting.”

Questions 50 and 51 address **pica behavior**. If either is marked “Yes,” the additional risk of **Aspiration/Choking** must be added to the ISP Risks page. The team must create an Aspiration/Choking protocol and a Support Document intended to prevent the Pica behavior. The Support Document(s) must address monitoring for aspiration, ingestion, poisoning, and blockage or perforation of the bowel. This may include Pica protocol, and/or intestinal obstruction protocol.

Question 52 addresses **physical aggression**. Though the ISP Manual does not provide a clear definition of this behavior, it can include, but is not limited to physically aggressive acts **that are intended to cause harm to another individual**, such as: hitting, kicking, punching, slapping, pinching, etc.

Question 53 addresses **self-injurious behavior**. Self injurious behavior is any behavior that presents an immediate risk of tissue damage to the person, or any behavior that, if continued, presents significant risk of tissue damage to the person in the near future. Self injurious behavior often refers to any behavior that can cause tissue damage, such as bruises, redness and open wounds. The most common forms of these behaviors include head banging, hand biting and excessive scratching or rubbing.

Question 54 addresses **property destruction**. Though the ISP manual does not provide a clear definition of this behavior, it can include, but is not limited to any **act that is intended to destroy/damage** other's property (can also include personal items or state property).

Question 55 addresses **leaves supervised settings (LSS)**. In the past this has been referred to as "AWOL," however this terminology should not be utilized as it was initially developed to describe actions taken by military personnel. Though the ISP manual does not provide a clear definition of this behavior, it can include, but is not limited to, any **attempts or actual efforts** to leave a supervised setting (e.g. ignore, on the behalf of the client, established staffing guidelines) within the community or home environment.

Question 56 addresses **unsafe use of flammable materials**. Though the ISP manual does not provide a clear definition of this behavior, it can include 2 broad categories:

1. Obtaining any flammable material(s) with the intent to cause physical harm to another individual (e.g. burning others with lighters/matches/cigarettes) and/or to cause property damage (e.g. burning down their home, lighting curtains on fire);
2. Using flammable materials unsafely, but without the intent to cause physical harm and/or property damage. For the latter case, it may not necessarily be a "tracked" risk, but rather more of need for building an individual's capacity for understanding the dangers associated with flammable materials. In addition, this scenario would be addressed in the individual's safety plan, rather than in the behavioral section of the RTR.

Question 57 and 58 addresses **drug and alcohol abuse**. A key component to remember when reviewing this risk is that single acts of often, self-reported use of drugs and/or alcohol, do not necessarily constitute "abuse." This is especially true for the consumption of alcohol, which is legal for any of the clients who are 21 years of age or older (though, for many of the clients that are supported within SOCP the consumption of alcohol is limited/prohibited due to other medical/behavioral issues). In addition, given the level of supports required by many of the individual's within SOCP (due to other medical/behavioral issues), the opportunity for individuals to engage in such dangerous behaviors is rather limited.

Question 59 addresses **unsafe social behavior**. This is any behavior that places others at risk of exploitation from the person, or places the person at risk for victimization from others. This can include, but is not limited to, verbally aggressive behavior (e.g. threats).

Question 60 addresses **undesirable sexual behavior**. Undesirable Sexual Behavior is defined as, but not limited to: Approaching others for sexual behavior that is unwanted/non-consensual; grabbing others genitals, touching other's breast(s), solicitation for sexual activity; Any of the following exhibited publicly: masturbation, fondling of others, fondling of self, talking about sexual activity or using sexual language, walking into an area disrobed; For individuals who are Sex Offenders, excessive staring and/or grooming can also be considered as undesirable sexual behavior.

Question 61 addresses **cruelty to animals**. Though the ISP manual does not provide a clear definition of this behavior, it can include, but is not limited to: any attempt or actual effort with the intent to cause physical or sexual abuse towards an animal such as: hitting, kicking, punching, drowning, fondling, intercourse, etc.

Question 62 addresses **use of objects as weapons**. Though the ISP manual does not provide a clear definition of this behavior, it can include, but is not limited to using inanimate and/or animate objects as weapons with the intent to cause physical harm to another individual. Weapons can include: chairs, phones, pens, knives, feces, etc.

Questions 63 addresses **illegal behavior**. Question 63 identifies when someone has engaged in behavior that is illegal, **whether or not** they have been charged or convicted of a crime.



It is important to understand the legal implications of being arrested, charged or convicted of a crime. These are as follows:

- **Arrested for a crime:** An arrest means only that an individual was taken into police custody and temporarily held by the police. An arrest is not a finding that the individual is guilty of a crime – or that they have done anything wrong at all. Arrests can lead to charges, then convictions. If it does not lead to either of these, then the individual is **not** guilty of a crime.
- **Charged with a criminal offense:** After an individual is arrested, the legal system will determine whether or not to officially charge them with a particular crime. Once charged, an individual may go to court to face an official trial, they may be placed on diversion, or the charges may be dropped, among other options.
- **Convicted of a crime:** A conviction means that the individual has been found guilty of a crime by a court or that they have agreed to plead guilty to a crime. There are many levels of crimes, including both misdemeanors and felonies. If the individual is found guilty of, or plead guilty to, any level of crime, they are generally considered to have a conviction. The individual may have been convicted of a crime even if they did not spend any time in jail. If the individual paid a fine, were put on probation, did community service, or received a conditional or unconditional discharge in connection with a crime, they may still have a conviction record.

What if Q1: Technically speaking, the RTR questions #52,54-62 could be considered “illegal” behavior (e.g. physical aggression can be considered as Assault, undesirable sexual behavior could address such illegal acts as Rape). Do we still mark “yes” on question #63, if we already marked “yes” for such questions as #52 (Physical Aggression)?

What if A1: Ultimately, this will be a team decision. The ISP manual does allow for both risks to be marked “yes.” The following are options for possible courses of action:

- a. If the team decides to mark “yes” for both physical aggression and illegal behavior (as an example), the BSP does not have to formally track the illegal behavior. For example, if an individual is physically aggressive and has been arrested for Assault, formal data collection does not need to occur for Assault (i.e. this does not need to be addressed through the “Behaviors to Decrease” section in the BSP). Rather, the BVS2 would make a note in the “notes section” of the RTR indicating something to the effect of:

“Client was charged with Assault in 1990, however no conviction was provided. The team agrees that the risk remains as a present issue, however all assaultive acts will be formally tracked as physical aggression. The BSP will provide supports to minimize this risk through those identified for physical aggression, as well as, through environmental supports such as the community guidelines and supervision levels.”

NOTE: *The important thing to remember is to identify how the BSP will address the illegal behavior. This can be through other behavior supports for “formally tracked” risks (e.g. Undesirable Sexual, Use of Objects as Weapons), as well as through such environmental and/or preventative supports such as media guidelines, supervision levels, restrictions on community access, etc.*

- b.** The team can decide to mark “history” for the illegal behavior. In this case, the BVS2 would make a notation in the RTR notes section of what the illegal behavior was, as well as, when it last occurred.
- c.** In either case, you will want to mention the illegal behavior in the psychosocial history section of the BSP.

What if Q2: What if an individual has engaged in a behavior such as “stripping.” This could be considered an illegal behavior (i.e. “public nudity,” and/or “indecent exposure.”). The individual has never been arrested, charged or convicted of this possible crime. Would we mark yes for RTR question #63?

What if A2: Again, this would be a team decision. Such a question would be best addressed through the options outlined in “A1” above.

Question 64 identifies when the individual has court mandated conditions or restrictions such as restraining orders, PSRB, Civil Commitments or Probation.

Question 65 identifies that an individual has a psychiatric diagnosis. Psychiatric diagnoses include: psychotic disorder (DO), schizophrenia and schizoaffective DO, depression, Bi-polar, conduct DO, adjustment DO, mood DO, personality DO, anxiety DO, impulse control, etc. (see Merck online medical library at: www.merk.com for more information).



Diagnoses on the Autism Spectrum, including Autism, Asperger’s, Rett’s, Torette’s, or Pervasive Developmental Disorder, as well as Mental Retardation are considered to be developmental diagnoses, not psychiatric diagnoses. However, the agency has determined that these diagnoses will continue to be coded under question #65.

Question 66 addresses suicidal attempts, gestures or threats.

Question 67 is designed to identify other important serious behavior issues that have not been addressed through the previous questions.

Risk evaluation: Questions # 60, 61, 62, and 66 require specific evaluations by a qualified professional to determine the current level of risk and support needs. A current

risk evaluation can be critical in order to fully understand an identified risk, and can be crucial when it comes to being able to provide supports that minimize the risk. ISP teams should seek out qualified professionals that practice positive behavior support strategies.

These evaluations can include the FA process of the Blended Plan, psychosexual evaluations and/or evaluations performed by an individual's psychiatrist/psychologist.

List the type of evaluation that was completed, the date of the evaluation, and where the document is located at the bottom of this section. A new evaluation does not necessarily need to be completed each year. An evaluation is considered current if the ISP team knows what the condition of the person was when the evaluation took place and the condition of the person has not significantly changed since the evaluation.

The relevant evaluations should be kept with the RTR for easy reference.

Annual review/Updates to the Risk Tracking Record (RTR)

A **Risk Tracking Record (RTR)** is completed once and reviewed annually at minimum. Annual reviews occur at the Pre-Meeting. Throughout the ISP year, updates that occur must be communicated with all ISP Team members. Changes to the body of the RTR may be either made directly on the RTR page, or the existing page may be removed and replaced with a new one. If making a change directly onto the page, be sure to date the change so it is clear to others which markings are current.

The RTR page that is updated should be completed by the ISP team member initiating the change. Once the Updates page is completed, copies of the updated RTR page and Updates page are distributed to the ISP team for their records. These updates become originals and originals are sent to Services Coordinators for adult services and Residential Specialists for children services. When updated RTR pages replace the current page, the replaced page is to be archived.

During the annual review, the current "Cover page" and "Updates pages" are removed and archived. A new Cover page with Updates is put in place, creating at least one new original page.

Summary: Overall, the RTR is used by the Behavioral Specialist in the following manner:

1. To offer a framework for defining maladaptive behaviors.
2. To inventory maladaptive behaviors identified through the functional assessment process.
3. To review any contributing medical/psychiatric/environmental conditions that either impact, direct, or motivate an individual's behaviors (both positive and negative).
4. To develop support documents that may be utilized to identify steps to prevent/minimize the risks associated with the behavior(s) (Behavior Support Plans).

OTAC downloadable forms: <http://www.otac.org/isp/isp-forms-021407/>

Click here to download the new [9.9.09 ISP Forms and Manual](#). Click here to learn more about the [required timelines](#) for switching to the new forms. The 2.14.07 forms on this page will remain available until February 15th, 2010.

An eight minute video is provided to cover the scope of changes, what is provided and how to get support. [8-minute overview video](#)

OTAC download forms

Are you looking for the new 9.9.09 forms?

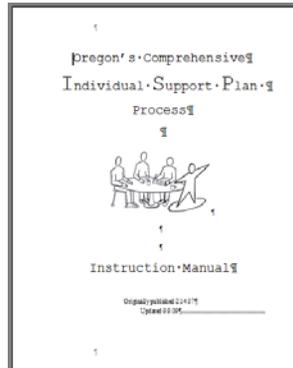
Click here to download the new 9.9.09 ISP Forms and Manual. Click here to learn more about the required timelines for switching to the new forms. The 2.14.07 forms on this page will remain available until February 15th, 2010.

2.14.07 Form Download Page

2.14.07 Form	MS Word Template	Handwritten Forms
Personal Focus Worksheet	download	download
PFW Supporting Questions	n/a	download
Risk Tracking Record	download	download
RTR Additional Updates Page	n/a	download
Protocol-Aspiration-Choking	download	download
Protocol-Constipation	download	download
Protocol-Dehydration	download	download
Protocol-Seizure	download	download
Financial Plan	download	download
ISP Meeting Agenda	download	download
Individual Support Plan (ISP)	download	download
Change Form	download	download
ISP Manual	n/a	download

Internet Explorer users: Right-click on "download" and choose "Save target as..."

9.9.09 ISP Manual



Required deadlines

ISP 2009: Timeline Requirements

Timelines at a Glance

You may begin using the revised ISP forms as soon as you receive them. No additional training is necessary. We recommend you review the "Summary of Changes" sheet that will be distributed with the revised forms. Here are the required dates by which the new forms must be used.

January 1, 2010

Any PFW & RTR started from this day forward must use the new forms

February 15, 2010

Any ISP started from this day forward must use the new forms

When you create an ISP after those dates, you must use these forms for all parts of the process: new PFW, new RTR, new Agenda, and new ISP. You must use new Fall four protocols and Financial Plan as well. The changes are significant enough that even if you have an existing protocol that wouldn't have needed any changes, it will need to be recreated on the new protocol form in time for the person's next ISP meeting.

[Individual Support Plans, ISP 2009, Requirements](#)

This entry was posted on Monday, August 24th, 2009 and is filed under [ISP Pipeline Newsletters](#), [Individual Support Plans](#). You can follow any responses to this entry through [RSS 2.0](#). You can skip to the end and leave a response. Pingbacks are currently not allowed.

The Functional Assessment and Behavioral Support Plan

Overview: The **Behavior Support Plan (BSP)** (DHS 4588 SOCP FA/BSP blended plan) is the primary support document utilized as a medium for detailing clear instructions that tell staff persons how to prevent and/or minimize behavioral risks identified by the RTR.

A **Functional Assessment (FA)** is the first step in developing a **Behavior Support Plan (BSP)**. It is a comprehensive and individualized strategy to:

- Identify the purpose or function of an individual's problem behavior(s)
- Develop and implement a plan to modify variables that maintain the problem behavior.
- Teach appropriate functional alternatives using positive and person-centered interventions.

DHS 4588_FA/BSP Blended

BVS2: The FA is conducted by the Behavioral Specialist at least 45 days prior to an individual's ISP.

According to OAR (411-325-0340(3)(a-e) the FA must include the following:

- A clear, measurable description of the behavior which includes (as applicable) frequency, duration and intensity of the behavior;
- A clear description and justification of the need to alter the behavior;
- An assessment of the meaning of the behavior, which includes the possibility that the behavior is one or more of the following:
 - An effort to communicate;
 - The result of medical conditions;
 - The result of psychiatric conditions; and
 - The result of environmental causes or other factors.
 - A description of the context in which the behavior occurs; and
 - A description of what currently maintains the behavior.

Interview and observation form samples and links:

DHS: SENIORS AND PEOPLE WITH DISABILITIES
State Operated Community Program

Functional Behavioral Assessment Interview Questions

1. In what ways does the individual communicate his basic wants and needs?
2. What does the individual seem to like and not like (including, activities, food, housemates, settings)?
3. Are there factors external to the setting that might be associated with the behavior (such as sleep patterns, medicines, diet)?
4. What do the problem behaviors look like?
5. What events are likely to make the behavior occur?
6. Are there events or conditions within the setting that seem to be associated with the problem behavior even though they may not immediately precede its occurrence?
7. Are there any events and situations that happen just before the problem behaviors that consistently predict that the problem behaviors will *not* occur?
8. What outcomes appear to maintain the problem behavior?
9. Does the individual exhibit any appropriate behaviors that would produce the same outcomes that appear to be maintaining the problem behavior?
10. What have been the outcomes of previous interventions?
11. What have been the outcomes of previous interventions?

Functional Behavior Assessment (FBA)
Interview questions
(1 page)

DHS: SENIORS AND PEOPLE WITH DISABILITIES
State Operated Community Program

Functional Behavioral Assessment Interview Form

Individual: _____ Interviewer: _____
 Interviewee: _____
 Include title and shift: _____
 Date: _____

Describe the problem behaviors:
 Define each problem behavior that is of concern. Include information about what it looks like, how often it occurs (per day, week, month), how long the behavior lasts and how damaging or destructive the behaviors are when they occur.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Describe the person's social behaviors.
 Define positive social behaviors you have observed the person perform. Include information about what it looks like, how often it occurs (per day, per week, month) and when you are most likely to see the behavior.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FBA: Interview Form 1 (11/08)

FBA Assessment Interview form
(8 pages)

DHS: SENIORS AND PEOPLE WITH DISABILITIES
State Operated Community Program

Client Observation Form

Individual: _____
 Date(s): _____ Observer: _____
 Behavior of concern: _____

	Date: _____ Time: _____	Date: _____ Time: _____	Date: _____ Time: _____
Setting/circumstance			
Antecedent			
Behavior			
Intervention			
Outcome			

Client Observation form

DHS: SENIORS AND PEOPLE WITH DISABILITIES
State Operated Community Program

Client Observation Form

Individual: Joe
 Date(s): 1/7, 1/8 Observer: BVS2
 Behavior of concern: Physical Aggression

	Date: <u>1/7</u> Time: <u>10-10:15</u>	Date: <u>1/8</u> Time: <u>2p-2:30p</u>	Date: <u>1/8</u> Time: <u>4:30p-5p</u>
Setting/circumstance	Preparing for outing	Returning from outing	Preparing for dinner
Antecedent	Staff getting money for the outing (had to wait for site manager to prepare)	Unable to determine	Smell of food - cooking
Behavior	Hit peer	Cussing, yelling at staff	Cussing, yelling, hit wall with fist
Intervention	Cued to stop;	Went to room to listen to music (part of calming strategy)	Was asked what was wrong, indicated was hungry, staff offered salad; utilized problem solving
Outcome	Continued to escalate; after PPI, talked to SM and BVS2, used problem solving, calmed	Continued with day with no issues	Used problem solving; no issues later

Client Observation Form 1 (11/09)

Client Observation form (sample)

Conducting the Functional Assessment (FA):

Define the Behavior and Collection Data

STEP 1 Define the problem behavior (as categorized by the RTR). A well defined behavior is essential when collecting data and communicating results with other team members.

BVS2: Define the behavior in specific, observable, and measurable terms. In other words, something you can see and count. For example, this is too vague: Joe is aggressive. Instead, the following is a behavior that you can see and measure: Joe pokes, hits or kicks others.

STEP 2 There are two basic methods for collecting data, direct and indirect.

Indirect methods include, but are not limited to the following methods:

- **Interviews:** Gleaned from the individual, staff, and people closest/most important to the individual.
- **File review:** This includes reviewing past evaluations / BSPs / FAs / RTRs / Medical / Safety / Financial Plans / behavior data, placement history, etc.

Direct methods record situational factors surrounding the problem behavior and include such methods as:

Direct observation: Using **Client Observation Forms** to observe both adaptive and problem behaviors; document setting events, staff/individual reaction/interventions and outcomes of these interventions/reactions.

- These can be used to determine if current interventions (as written in the plan) are working or not working, or if new ones have emerged.
- Direct observation can also be used to determine if staff is following the plan as written.
- Outside of conducting these observations for the purpose of the FA process, the client observation forms should be completed on a regular basis and kept in a file with the staff/client interviews for each year.



Another form of Direct Observation includes working directly with the individual. This can be done over an entire shift, accompanying the individual on an outing, or by spending an hour or more working with them. Such “hands-on” observation can provide you with invaluable information about whether or not specific strategies are working or not working, further informing the FA process.

BVS2: When using both direct and indirect methods, watch for factors that may be influencing the individual’s behavior, keeping in mind the possibility that the behavior is one or more of the following:

- An effort to communicate
- The result of medical conditions
- The result of psychiatric conditions
- The result of environmental causes or other factors



If, prior to or during the FA process the team identifies that a medical concern such as, a dental problem, ear infection or allergies is fueling an individual's dangerous behaviors, the team can address these issues in documents such as Medical Supports or Medical Guidelines. If these supports alleviate the dangerous behaviors, then no further action is required regarding behavioral supports.

In addition, if an individual's dangerous behaviors are alleviated through a change in either the way staff interacts with them and/or through changing the environment, a BSP may not need to be developed. The team may consider "Interaction Guidelines" or a "Good Day Plan" as a means of alleviating the behavior. However, these guidelines must focus solely on staff interactions and environmental factors (*see, What to do when the Team has determined that form behavior supports are not needed.*)

Summary: By using a variety of direct and indirect data collection methods, you will be able to determine the following:

1. **Setting events:** What sets the stage for the behavior. For example, noisy environments, lack of funds, lack of meaningful relationships (e.g. boyfriend/girlfriend).
2. **Triggers:** What sets off/triggers the behavior. For example, being told "no," seeing other people engaged in meaningful relationships, allergy attack, house mate's behavior, having to wait.
3. **Precursors:** How the individual lets us know that they are going to engage in the behavior. For example, face gets red, intensely stare, go blank, stomp their feet, breathe heavily, swear, speech becomes erratic.
4. **Frequency/intensity and duration:** This information will not only guide how data is collected on the behavior (See data collection), but also inform whether or not the behavior is placing the person at risk (see RTR section).
5. **When the behavior is most/least likely to happen:** This identifies some environmental issues that may impact, drive, motivate the behavior. For example, does a behavior always occur during mealtimes?
6. **Behavior chains:** Is there a general/predicable order to the behavior(s). For example, does an individual usually engage in verbal aggression then does this progress to physical aggression?
7. **Response classes:** Do particular behaviors occur together and appear to serve the same function/have the same meaning?
8. **Contributing mental health/medical conditions:** These are variables that may have an impact, drive, or motivate the behaviors.

- 9. Socially appropriate behaviors:** These are skills/strategies that the individual is already using/capable of using to decrease their maladaptive behaviors.
- 10. Communication:** What are the individual's expressive and receptive skills? How do they communicate when in distress?

STEP 3 Identify and explain the function of an individual's problem behavior. This is accomplished through two primary steps: Data Review and Formulating a Hypothesis.

BVS2: Data Review is the process of gathering and reviewing data with the goal of highlighting useful information, suggesting conclusions, and supporting decision making. As it applies to the Functional Assessment, this process is simply pulling together all of the information gathered on a specific problem behavior (e.g. setting events, triggers, where/when/with whom the behavior is most/least likely to occur/communicative abilities/mental health diagnosis, etc;).

Summary: Ultimately, data review is a process that looks beyond the overt topography of the behavior, and focuses, instead, upon identifying biological, social, affective, and environmental factors that impact, drive or motivate the behavior.

STEP 3B Only when the relevance of the behavior is known is it possible to speculate the true function of the behavior and establish an individual behavior support plan. This relevance can be determined through the data review process described above. In other words, before any plan is set in motion, the Behavior Specialist (and ultimately the team) needs to formulate a plausible explanation (hypothesis) for an individual's behavior. Ultimately, formulating this hypothesis is a process that attempts to explain the function of an individual's problem behaviors, given specific factors or contexts identified through the data review process.

BVS2: In its simplest form, a hypothesis will address the following statements:

Statement	Examples
"When this occurs" or "During this time"	Triggers, Setting Events, Psychiatric condition Mealtimes, Shift Change, After family visits **Note: This information is gleaned from your data review.
"The individual does/engages in"	Description of the problem behavior: Physical Aggression, SIB, LSS **Note: This information is gleaned from your data review.
"In order to" "To obtain"	This is the function of the behavior(s). Some examples include: To initiate social interaction, to escape a demanding situation, to express anxiety/fear/anger.

Summary: The key to gaining insight into the function an individual's behavior is to examine the functions of our own behavior. Efforts to resolve conflict, express anxiety,

gain access to a social group, maintain friendly relationships, avoid embarrassment, and please others are all completely normal behaviors. However, these behaviors become “problems” once they are expressed in socially/culturally inappropriate means (i.e. They challenge our social norms: Stealing to get items that an individual wants v. maintaining a job to earn money to pay for the item(s); Punching someone that has made an individual angry v. Following steps of conflict resolution, or ignoring).

STEP 4 Develop a “**Functional Alternative**”. The functional alternative can be viewed as a functional/positive/constructive “replacement” behavior for the individual that accomplishes the same purpose of the individual’s problem behavior.

BVS2: When developing a functional alternative keep in mind, an individual may engage in a problem as a result of the mental health/psychiatric diagnosis (es) (a pre-set):

Psychiatric illnesses may act as an establishing operation (i.e. “reason” or “function”) for the problem behavior in individuals. Psychiatric influences can be conceptualized as internal events within a person’s biological system that partly determine an individual’s response to the environment.

To illustrate, consider the following examples:

An individual lives in a small group home with three other individuals. On a given day, four staff persons were scheduled to work so that people could attend a long anticipated community event. Unfortunately, two of the staff people were sick leaving only two staff on-duty, and insufficient staffing precluded attending the community event. Most of individuals were disappointed, but one man with a diagnosed mental health disorder reasoned that the two sick staff feigned illness and the other two were too busy to pay attention to him. He became suspicious whenever they interacted with others. When he and others were asked to assist in a household task, he refused and began to verbally assault staff the individuals around him. When asked to calm himself, he physically attacked the staff on duty.

A young woman with mild mental retardation has been increasingly withdrawn. She lives in a small group home and spends most of the day in her room. She is in danger of losing her job due to frequent absences. In the morning, the group home care providers awaken her and give her prompts to get ready for work. She refuses and uses some profanities. A little time passes, and concerned that she will be late again, a preferred staff member repeats the prompt to be up and get ready. The young woman screams at her, and hits the staff member. The staff member retreats, frustrated and angry in response to the assault. Staff begin to speak of her as lazy, resistive and aggressive. They meet and decide to develop a behavioral intervention using a mixture of incentives (access to preferred activities) and punishments (loss of preferred activities) to get her to go to work and be more involved in social activities. The

intervention is unsuccessful. The young woman becomes increasingly withdrawn and aggressive. She refuses food and is eventually hospitalized.

In this case, the young woman's depressive illness serves as an establishing operation that reduces the reinforcing value of work (paycheck) and social activities (interaction). Due to her depression, the young woman experiences increased feelings of fatigue and lack of enjoyment in previously preferred activities. Prompts to go to work or engage in activities are perceived as aversive events triggering refusals and aggression. When the young woman displays physical aggression, staff become fearful and cease prompting her, making it more likely that aggressive behavior will be repeated. Because staff lack an understanding of the relationship between depressive symptoms and the young woman's behavior, their attempts at intervention not only fail, but make matters worse.

BVS2: An individual may engage in a problem behavior:

- As they lack the skills to engage in a more appropriate behavior, or
- Because they lack appropriate, alternative skills and truly believe that their behavior is effective in getting what they want or need.

For example, an individual may engage in physically violent behavior because they believe that violence is necessary to efficiently end a confrontational situation, and may believe that these behaviors will effectively accomplish their goals. However, when taught to use appropriate problem-solving techniques, the individual will be more likely to approach potentially volatile situations in a nonviolent manner.

If this is the case, the functional alternative may address that deficit by including, within the BSP, a description of how to teach the problem-solving skills needed to support the individual. This description would include the supports, aids, strategies, and modifications necessary to accomplish this instruction, with expectations explained in concrete terms.

BVS2: An individual may engage in a problem behavior:

- Even though they know the skills necessary to perform the appropriate behavior, they do not consistently perform these skills (i.e. they lack motivation, and/or do not see the intrinsic value of engaging in the appropriate behavior).

If this is the case, the functional alternative will want to include techniques, strategies, and supports designed to increase motivation to perform the skills.

In addition, techniques would want to be developed for making the appropriate behavior more desirable. These strategies, techniques and supports will need to be concretely explained within the BSP.

BVS2: An individual may engage in a problem behavior:

- Due to both skill and motivational deficits.

If this is the case, the functional alternative will want to include techniques that combine both learning activities and strategies for making the appropriate behavior more desirable.

Explaining Functional alternative strategies, techniques and supports “**concretely**” refers to the following:



Providing a picture of the **Functional Alternative**: What staff is to do / when / where; what the individual is to do/when/where. Such a “picture” may entail specific steps for staff and/or the individual to follow. By providing a concrete explanation of the functional alternatives, you will ensure that staff is following-through with the identified techniques, strategies and supports in a consistent manner. Such details can help to rule out whether or not a functional alternative is/isn’t working due to such variables as, staff not understanding how to implement, and/or implementing incorrectly.

Summary: A functional assessment has five primary goals:

- a) To define the problem behavior in a clear and measurable manner,
- b) To describe the events, times, and situations that predict both the occurrence and nonoccurrence of problem behavior,
- c) To identify the variables maintaining problem behavior, and finally,
- d) To generate and confirm hypotheses regarding the function(s) maintaining problem behavior, and
- e) To develop functional alternatives that will determine strategies for supporting an individual to engage in new behaviors that maintain their safety, health, independence and dignity.

The functional assessment should include consideration of any relevant psychiatric disorders as a potential establishing operation (e.g. “function,” “reason”).

It is important as well to consider how the psychiatric disorder(s) might increase the salience of environmental events. By combining information related to psychiatric symptoms as well as, non-psychiatric symptoms, can eliminate the frequently asked dichotomous question, “is it behavior or is it mental illness?”

The most accurate answer to this question is often “both.”

Behavior Support Plan

Overview: A Behavior Support Plan (BSP) is a Support Document used when ISP teams feel that interventions are needed for identified behavioral risks. The ISP team must make the decision to create a BSP.

A BSP attempts to change a person's behavior through positive supports and must be written in accordance with current OIS practices and follow OAR's specific to the service provided.

If interventions are needed or other information indicates a BSP is needed, a BSP must be developed. The ISP team must document that each member is aware of this plan; the ISP Signature page is sufficient.

BVS2: The BSP must be **completed 7 days prior** to an individual's ISP. According to the OARs (411-325-0340(4-5), the minimum requirements the BSP must address the following:

- a) An individualized summary of the person's needs, preferences and relationships;
- b) A summary of the function(s) of the behavior, (as derived from the functional behavioral assessment);
- c) Strategies that are related to the function(s) of the behavior and are expected to be effective in reducing problem behaviors;
- d) Prevention strategies including environmental modifications and arrangement(s);
- e) Early warning signals or predictors that may indicate a potential behavioral episode and a clearly defined plan of response;
- f) A general crisis response plan that is consistent with the Oregon Intervention System (OIS);
- g) A plan to address post crisis issues;
- h) A procedure for evaluating the effectiveness of the plan which includes a method of collecting and reviewing data on frequency, duration and intensity of the behavior;
- i) Specific instructions for staff who provide support to follow regarding the implementation of the plan; and
- j) Positive behavior supports that includes the least intrusive intervention possible.

Putting it all on together: The FA/BSP Blended Plan

Overview: The blended plan is a behavior support document that combines the aspects of the Functional Assessment and Behavior Support Document into one document. The purpose of this blending is to reduce unnecessary repetition, increase continuity across the agency, and to develop effective behavior supports for the individuals supported.

The components of the blended plan are as follows:

I. Client profile

Individuals interviewed and/or consulted for the Assessment Plan

Date interview process is started:

Use this date on RTIs, ect.

Client identifying information:

Psychosocial history:

Review of dangerous behaviors:

BELOW: In number 1-12 type the Name of the specific behaviors and behavior details.

Section 1: Client Profile

BVS2: This section is made up of the following sub-headings:

1. **Individual's interviewed/consulted for the assessment plan.** These are individual's that were interviewed during the FA process of indirect data collection (e.g. FA interviews form, Client interview form). Dates of when the interviews were conducted will be provided in this section.
2. **Client identifying information**, this includes their date of birth, diagnosis, any physically identifying characteristics (e.g. glasses, tattoos, AFO's, amputations, blindness, etc;)
3. **Psychosocial history**, this includes (as applicable) the following:
 - a) Developmental history (*physical, emotional, cognitive, educational, nutritional, and social development, normative development for chronological age)
 - b) Individual history
 - c) Family History (Interpersonal and family relationships)
 - d) Family circumstances (*family relationships and how these affect needs of the individual)
 - e) Family history of alcohol abuse
 - f) Family history of emotional illness
 - g) Current living situation
 - h) Usual social, peer-group, and environmental setting
 - i) Education history
 - j) Sexual history (rape, sexual molestation)
 - k) Physical /emotional abuse (domestic abuse, neglect, exploitation)
 - l) Substance abuse (age of onset, duration, patterns of use)

- m) Occupational/Vocational history
- n) Legal history / record of arrests / violent behavior
- o) Financial status
- p) Review of their behaviors including where/when most likely to occur, intensity and severity.

Review of dangerous behaviors:

BELOW: In number 1-12 type the Name of the specific behaviors and behavior details.

Name of behavior 1.
Frequency: _____
Context: _____
Duration: _____
Intensity/severity: _____
<input type="checkbox"/> Interferes with community or social participation <input type="checkbox"/> Threatens the safety of others or infringes on the rights of others <input type="checkbox"/> Interferes with skill acquisition or other activities <input type="checkbox"/> Is a risk to the health or safety of self

4. **Review of Dangerous Behaviors:** This section should cover the intensity/severity and general frequency of each behavior identified through the RTR. In addition this section covers the “Context” in which the behavior occurs, as well as it’s general duration. **Note: The behaviors need to be listed as they are labeled by the RTR and in the order that they appear on the RTR.**

Why the Behavior(s) need to be altered: This is a check box to determine whether or not a behavior needs to be altered as it interferes with: Community or Social Participation, Skill Acquisition or other activities, threatens the safety of others or Infringes on the right of others, Is a risk to the health and safety of self, or any other applicable reason. The process for determining this has already been completed as the RTR was developed.

5. **Contributing “Medical Conditions” that may have an impact on an individual’s behaviors.** This section should answer the following, as applicable:
- a) Does the individual have any medical conditions that may have an impact on their behaviors (e.g. allergies, obesity)?
 - b) How do these conditions impact an individual’s behaviors? Do behaviors increase/decrease as a result of seasonal allergies (i.e. during the winter an individual’s behaviors are lower than in the summer).
 - c) Does the medical condition act as a setting event or trigger to an individual’s behavior? For example, an individual may be obese and on a limited calorie diet. As a result, this individual’s behaviors tend to increase as a result of wanting more food items than their current diet will allow.
 - d) Current medications that have been prescribed for the treatment of a psychiatric condition, which may influence behavior (name only).
 - e) Changes in medications and possible effects on behavior.

6. **How the mental health diagnosis manifests in the individual.** This is a distillation of how an individual’s mental health diagnosis (es) affects their functioning in their everyday life activities, interpersonal relationships, etc. In many ways, this section serves as a means to define a particular diagnosis (e.g. Bipolar Disorder, Antisocial Personality Disorder) in general terms and then relate it to specific manifestations in the individual. The following example pertains to an individual diagnosed with Antisocial Personality Disorder:

- a) *The characteristics of Antisocial Personality Disorder include a longstanding pattern of disregard for the rights of others. There is a failure to conform to society’s norms and expectations that often result in numerous arrests of legal involvement, as well as a history of deceitfulness. A major component of this disorder is the reduced ability to feel empathy for other people.*
- *Bill displays many of these characteristics and they appear to drive many of his maladaptive behavior.*
 - *He has a long history of legal involvement and assaultive behaviors, impulsiveness and a lack of regard for the authorities.*
 - *He often rationalizes negative behavior by blaming others, and has historically denied or avoided accountability for his actions.*
 - *For example, when questioned about shoplifting, he has responded with: “What choice did I have?” “I didn’t have enough money, and I needed the CDs.” “I have never had any one to help me, it’s always me against everyone else.”*

You can look up many of the individual’s diagnoses (both medical and psychiatric) on such websites as: www.mayoclinic.com, www.merk.com, and www.nlm.nih.gov.



These websites can give you insight into the general characteristics of each diagnosis. You can then utilize your professional opinions to determine which diagnoses have the most salient impact on an individual’s behavior, as well as, determine which general characteristics of the diagnoses an individual specifically engages in/displays.

II. Client needs, preferences, relationships

Needs:

Preferences:

Relationships:

Expressive communication:

Receptive communication:

Communication in distress:

Section 2: Needs, Preferences, Relationships and Communication

BVS2: This is a **review** of an individual’s needs, preferences, and relationships as taken from the PFW. This is not a word for word detail. It is up to the BVS2’s professional opinion to determine which needs, preferences and relationships to

include in this section. The review should highlight needs, preferences, and relationships that either impact, direct or motivate an individual's behaviors (both adaptive and maladaptive). In addition, this section includes a review of the individual's communicative abilities and needs to address the following:

- Expressive Communication
- Receptive Communication
- Communication when in Distress



Be sure to include the sentence, “**See current Personal Focus Worksheet (PFW) for more information**” in this section.

Section 3: Behavior definitions

Behaviors to decrease :

Some have similar or the same “Triggers”: Used to support client in learning how to express his concerns in an appropriate manner.

Elaborate in first reference similar “Triggers” and “Precursors.” Check box if different and explain.

Setting events: _____

Triggers: _____

Precursors: _____

Name of behavior **1.**

Definition:

- | | | |
|---|---|---|
| <input type="checkbox"/> Trigger same first reference | <input type="checkbox"/> Precursor same first reference | <input type="checkbox"/> Setting event same first reference |
| <input type="checkbox"/> Trigger different, explain: | <input type="checkbox"/> Precursor different, explain: | <input type="checkbox"/> Setting event different, explain: |

Data collection: _____

Alteration criteria: _____

This section covers the following: Behavior definitions, Setting Events, Triggers, and Precursors for each behavior(s), data collection methods, as well as Alteration Criteria. This section is organized in a table format.

BVS2: Behavior definitions, these are the definitions of the behaviors identified through the RTR and FA process. The definitions need to be listed as they are labeled on the RTR, as well as, in the order that they appear on the RTR.

Setting Events, Triggers, Pre-cursors: Setting events are the environment, activity, or condition in which the tracked behavior is likely to occur. Triggers are things that happen to or around an individual that is likely to “push” the individual into engaging in a maladaptive behavior. Precursors are signs that an individual portrays that clue support staff into knowing when an individual is upset and/or going to engage in a maladaptive behavior (e.g. staring, going red in the face, being quiet, yelling, breathing heavily). Each of these components will be determined through the FA process (e.g. indirect and direct data collection).



Setting Events, Triggers and Precursors can be grouped together, if they are the same for each (or a particular set) of tracked behaviors. This can come before or after the Behavior definitions.

For example:

Setting Events: The setting events for all of Joe’s behaviors are as follows: noisy environments, Lack of preferred activities, Shift Changes.

Triggers: The triggers for all of Joe’s behaviors are as follows: Being told “no,” interruptions to preferred activities....

Pre-Cursors: The pre-cursors to all of Joe’s behaviors are as follows: clinching fists, scowling, intently staring at a targeted individual....

Data Collection

Behavior data can serve many functions. It can be used to establish a baseline of the target behaviors to increase or decrease.

Data can give us information on when and where behaviors are most likely to occur, as well as how often, how long, how much, how intense and with whom and as a result of what. Behavior data allows for the comparison of behavior pre and post intervention. The analysis of data tells us whether our interventions are effective and should guide our decisions on making changes to a program, including whether to continue with an intervention.

There are four (4) main types of data collection:

- ***Frequency***
- ***Interval***
- ***Duration***
- ***Intensity***

Frequency: This is an exact count of how many times a specific behavior occurs. It is used by observers who are interested in counting the exact number of times a behavior occurs. A tally is made each time an individual engages in the target behavior. To use frequency recording, the behavior must be observable and have a clear beginning as well as a clear ending.

Frequency recording is difficult to use when the behavior is occurring at such a high rate that an accurate count is impossible, or when the behavior occurs for extended or variable amounts of time.

Interval: Interval recording is best used for behaviors that appear continuous. It provides an estimate of the actual number of times that a behavior occurs. One hash mark or tally is utilized to indicate if a behavior occurred within a specified time frame (e.g. 3-15 minutes).

Keep in mind that data from interval recording represents an “estimate” of behavior rather than an actual count. Therefore, regardless of whether the behavior occurs once, twice or 5 times within the time interval it is only marked once to indicate that it occurred.

Duration: This method is used when the primary concern is the length of time an individual engages in a specific behavior. Duration recording documents the total time or percent of time that a behavior occurs within a specified time period. Duration recording can be used to measure behaviors emitted at high rates. Behavior is measured from the moment of onset until the moment it stops.

Intensity: This is measured when the force or magnitude of the behavior is the most important aspect of the behavior or the aspect of the behavior that is targeted for change. Intensity can be measured with a rating scale. For example, if the loudness of an individual's screaming during a behavior is being targeted for change, the observer may use a rating scale to measure the individual's behaviors during a behavior (e.g. loudness of screaming).

Summary: The key point to remember is that different types of behavior may require different data collection techniques. For example, if it is important to know how often a behavior occurs (e.g., hitting) a system that yields the number of behaviors, or *frequency or interval measure*, is appropriate.

At other times, knowing how long the behavior occurs is more relevant (e.g., screaming), so that a *duration measure* becomes more useful.

Furthermore, the usefulness of documenting the intensity of a behavior is evident when the team tries to measure the magnitude of a particular behavior. To say that Charles bit 2 staff may not reflect the fact that his one bite resulted in superficial marks, and the other resulted in a breakage of skin.

Section 4: Behavior Functions

IV. Behavior functions

Behavior chains / response classes:

Function of behavior(s):

Functional alternatives to behavior(s):

Incentive plan: Not applicable

BVS2: This section includes four (4) sub-headings:

1. **Behavior chains/response class:** Generated from the Functional Assessment (FA) process.
2. **Function:** Generated from the Functional Assessment (FA) process.
3. **Functional alternative:** Generated from the FA process. Each Functional Alternative will need to provide clear steps for staff to follow when supporting the individual. For example, "Problem Solving" should not just be listed as a functional alternative. Rather, you should go into the details of what "problem solving" looks

like for the individual. What steps are involved in the problem solving process?
How should staff respond/assist?

4. **Incentive plan:** Though an incentive plan is not a functional alternative, it can serve as a means to increase an individual's motivation to engage in appropriate behaviors, and/or make an appropriate behavior more desirable. This section needs to clearly outline the following:
 - a) What the incentive is
 - b) Why the incentive is being employed
 - c) When the incentive is earned
 - d) How the incentive is earned



Behaviors that are in the same response class (i.e. serve the same function) can be grouped together for each function. Behaviors that are in their own response class, need to be listed separately. For example:

Function

Property destruction, use of objects as weapons and physical aggression: May serve as a function of their Autism, or as a means to communicate that an individual is over stimulated, feels like they are being ignored, or possibly, as a means to communicate that they are experiencing high levels of anxiety and want to leave the area.

Self-injurious behavior: May serve as a means to self-soothe and center, express that the individual is uncomfortable.

Section 5: Proactive strategies

BVS2: This section details the proactive strategies or guidelines that are currently in place to reduce an individual's opportunity/need to engage in their tracked behaviors. It includes elements that are necessary in an individual's life in order for a successful day to occur and ways to increase the individual's quality of life. In addition, the Proactive strategies is about identifying problem areas for the individual and changing these situations by taking something stressful away, adding something comforting to, or changing something already in the situation prior to the individual experiencing the problem behavior(s).

Though this section has the potential to have several sub-headings, the following must always be addressed for each individual:

V. Proactive strategies												
Supervision levels (general)												
Check if applicable	Always	Frequently	Sometimes	Occasionally	Rarely	Never	Other	Not applicable	Not tracked	Not applicable	Not tracked	Not applicable
Not allowed in room												
1. Not												
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99. Not												
100. Not												
General staff interaction guidelines:												
Community access:												
Community re-entry procedure:												
Outing requests:												
Other:												

Supervision Levels (General)

Check if Applicable	Awake: Bedroom	Asleep: Bedroom	Bathroom	Kitchen	Living / Dining Room	Laundry Room	Yard	Stores	Parks	Restaurants	Crowded Community Events (fairs)
Not allowed in room	<input type="checkbox"/>										
3 - feet	<input type="checkbox"/>										
10 - feet	<input type="checkbox"/>										
In the same room	<input type="checkbox"/>										
Visual contact at all times	<input type="checkbox"/>										
15 - minute visual checks	<input type="checkbox"/>										
30 - minute visual checks	<input type="checkbox"/>										
Hourly visual checks	<input type="checkbox"/>										
Check visual every 2 - hours	<input type="checkbox"/>										
Other:	<input type="checkbox"/>										

Supervision levels (general): This section will address the general supervision levels that an individual may require in order to maintain their and other’s health and safety. This section is organized in a table format and covers the following supervision areas:

Supervision levels (other): This section will address any “other” areas that may apply to a particular individual. This section is also organized in a table format, however the table does not have to be utilized if it does not apply (i.e. it can be deleted and/or replaced with narrative). This section can cover a variety of areas, including, but not limited to the following:

- Special Olympics/Sporting Events, • Dances, and
- Special considerations (e.g. 2:1 in the community)

Note: Clients who’s ISPs occurred prior to June 1st, 2010 will have supervision levels detailed in a document titled “Staffing Expectations.” This document will remain valid (i.e. will need to updated and trained) until the individual’s new ISP. After June 1st, 2010, all client supervision levels will only be included in the BSP as outlined above.

General Staff Interaction Guidelines: For example, important day-to-day interactions such as treating an individual with respect; How to communicate (e.g. Does the individual have hearing aids, so staff need to speak up? Or does the individual have a special greeting, like bumping fists?); Are there certain approaches that work best when interacting with the individual, e.g. using humor, using very concrete sentences, short sentences, etc; Are there certain phrases/colors/subjects that should not be brought up in the individual’s presence?

Community Guidelines/Access: How an individual can request/attend an outing; conditions for doing so (i.e. no presence of behaviors?); Are their restrictions on when (day/time) or where and individual can go?

Restroom Guidelines: This section needs to address community restroom guidelines. Can an individual use any restroom? Can they only use a single occupancy restroom? What if a male staff is supervising a female client? What if a female staff is supervising a male client?

Section 6: Reactive strategies

VI. Reactive strategies

General:

Community:

BVS2: This section indicates Reactive strategies for each tracked behavior. The behaviors need to be listed in the order of the RTR and as they are labeled on the RTR. These are strategies that should only be implemented if any of the above PROACTIVE STRATEGIES have been unsuccessful in supporting the individual in engaging in productive/positive behaviors. Overall, the Reactive Strategies is about making the needed changes when behaviors start to show “early warning signs (e.g. precursors)” that often lead to problem behaviors.

These strategies can include cuing or prompting, increasing supervision, removal of items from room/area, switching out staff, PICA sweeps, and/or encouragement to engage in functional alternatives.

In addition, the reactive strategies must address the following sub-headings:

1. **General:** as applicable, this section could include such items as:
 - Verbal de-escalation in concrete terms(Tone, message, content)
 - Safe physical positioning during escalation to support co-workers
 - Implications for supervision during escalation (moving from 10 feet to 3 feet constant visual)
2. **Community:** This section needs to include strategies for supporting an individual if they engage in their behaviors, or are becoming escalated while in the community.

Other items to consider when developing the reactive strategies for each identified behavior include: determining whether or not risk assessments need to be pursued (e.g. suicide), specifically addressing what it means to “secure the area” (e.g. removing items, ushering clients into their bedrooms), as well as clarifying any open-ended statements such as, “return a client to the house,” “end the outing,” or “remove the item.”



If a particular reactive strategy applies to more than one of the identified behaviors, they may be grouped together. For example: **Property destruction, Use of Objects as Weapons:** Cue to stop, then....

Section 7: Crisis strategies

VII. Crisis strategies – BSP essential components

- 1) General:
- 2) Program approved PPI's:
- 3) When to abort the PPI:

PPI release criteria:

BVS2: This section details crisis strategies for the appropriate tracked behavior. Crisis strategies are when the above PROACTIVE AND REACTIVE STRATEGIES have failed to support the individual in de-escalating, and they are now to the point where they pose an immediate threat of harm to themselves, staff, or peers.

These strategies may include program approved PPI's, instructions for staff to keep their communication concrete and simple, limiting of choices, refraining from power struggles, etc.

In addition, the **Crisis strategies** must address (as applicable) the following sub headings:

General: This can include a variety of information such as:

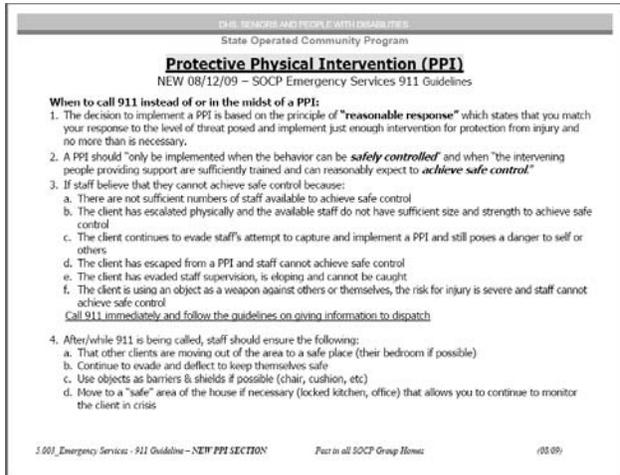
- a. Communication strategies,
- b. Pre-arranged roles that staff assume in a crisis
- c. With large clients (250+ lbs) prescribe minimum staff to implement a PPI safely
- d. Instructions for staff to refer to the **SOCP's Accessing Emergency Services guidelines** for directions on what to do in an emergency situation and when to call 911. Check the SOCP website for the most current guideline.
- e. If a specific PPI is unsafe to utilize for a particular individual/situation
- f. How an individual responds when in a PPI (e.g. is very flexible, typically engages in biting behavior, will attempt to immediately go to the ground, etc;)
 - **You may be providing supports to individuals who routinely engage in “spitting” behaviors during crisis. If this is the case, you will need to include the following in the general crisis strategies:**
 - A towel and/or spit mask may be utilized by staff for their protection. If the team agrees to these methods, you will need to indicate something to the effect of: “Client will spit during times of crisis. Spit masks/towels are available for staff to use for their personal protection. The spit masks/towel will be placed over the head of **the staff (or, if using a towel, in between the staff and client’s face).** **At no time** will the spit masks/towel be placed over or on the client's head/face. The spit masks can only be used once (do not share with other

The image shows a document header for the State Operated Community Program (SOCP) Emergency Services, dated 04/15/10. Below the header is a table with the following content:

THE SERVICES AND PEOPLE WITH DISABILITIES		
State Operated Community Program (SOCP)		
SOCP Guidelines: Emergency Services		
Accessing 911 and Emergency Services		
Action Requested:	SPD-AR-07-032	
Effective Date:	04/15/10	
These guidelines are NOT meant to replace any existing instructions in the client's Behavior Support Plan (BSP), Safety Plan or any individual Support Plan (ISP) Protocol. If staff believe an emergency exists they must immediately call 911 if faced with a serious injury or sudden illness including severe pain or the individual has a life-threatening condition, and do not need to call management before doing so. The Program Manager (PM), Program Administrator (PA), Clinical Services Manager (CSM) or On-Call Program Manager (OCM) are to be notified per the existing SOCP protocol for emergencies.		
Behavioral		
• Behavior Supports in BSP - Know your Behavior Support Plan (BSP). Know what REACTIVE and CRISIS STRATEGIES are written to prevent a crisis or contain one when it occurs.		
• Programmed PPIs - Know what Protective Physical Interventions (PPIs) are prescribed. Know what resources you have available to implement PPIs. Request additional staff if needed, consult with the Manager (SM), Program Manager (PM), Clinical Services Manager (CSM) or On-Call Program Manager (OCM) when appropriate. Remember that PPIs are only one of the strategies you have to manage a crisis.		
• Emergency PPI - If you are in a situation where you need to use a PPI not prescribed in the BSP or you do not have the staff resource to implement a prescribed PPI, all staff certified in Oregon Intervention System (OIS) have the authority to implement an emergency OIS technique. Remember the principles of "Maximum Response" taught in OIS class.		
• Staff Backup - Sometimes the addition of extra staff can help to contain a situation and prevent a behavioral crisis. Consult with your SM, PM or On-Call PM for additional staff.		
• Consultation - Sometimes a (phone) consultation with the SM, PM or CSM can de-escalate a client and the situation.		
• Know your client and whether the presence of police will escalate his/her behavior. If so, be prepared.		
The decision to call 911 should be made with the following guidelines:		
DECISION:	YES	NO
1. Have the instructed all strategies listed in the BSP?	Go on to question 2	Request and follow BSP
2. Is the most pressing behavior "risk of injury"?	Go on to question 3	Request and follow BSP
3. Can the emergency risk be contained by staff (BSP)?	Secure staff backup	Go on to question 4
4. Are additional staff available?	Secure staff backup	Go on to question 5
5. Can backup staff respond in time?	Wait for staff to contain client	Go on to question 6

employees). Staff will properly discard of these in a bio-hazard bag (i.e. red bag). Towels will need to be properly laundered.

2. **Community:** This section needs to include strategies for supporting an individual if they engage in their behaviors, or are becoming escalated while in the community.
3. **Program approved Protective PPI's:** Program approved PPI's according to each applicable behavior.
 - a. There may be cases where staff need to attach weight in order to safely maintain an individual in a PPI. In cases where this applies, you will want to specify in this section that additional staff may be needed as attached weight.
4. **When to abort the PPI:** This should describe, as applicable when staff should abort the PPI as it can be unsafe for both staff and the individual.



Release: This section also includes instruction for staff on when to release an individual from a PPI. Ultimately, what calm looks like for the individual. This may be a change in breathing patterns, verbalizations, relaxed muscles, etc. However, for some individuals, they may say that they are calm and ready to be released, however, they will often use the release as an opportunity to re-escalate. Information such as this, should be detailed in this section and possible strategies for overcoming this, should be described.

Program approved PPI's:



Program approved PPI's must be in keeping with currently approved OIS physical intervention techniques. If particular PPI's would be more appropriate in keeping an individual safe, and the technique **is not** currently approved, the Behavioral Supports Manager and the Clinical Services Manager will need to be consulted. Once this consultation has taken place, and the ISP team agrees to pursue the specialized PPI technique, a request will be made to the OIS Steering Committee to bring the case to their monthly meeting.

Preparing for a Steering Committee presentation:

Step 1 Develop a Letter Requesting Authorization

- ✓ Develop a letter on State DHS letter head (see example on SOCP website) requesting authorization for a specified PPI restraint/procedure
- ✓ The letter should include a paragraph describing the client as follows:
 - Redacted name (change the name, don't use XXX)
 - Height/weight
 - Diagnosis
 - Brief description of the living environment
 - Current psychotropic medications
 - Any other information pertinent to the requested PPI restraint/procedure.
- ✓ In addition, the letter should provide an explanation of the proposed PPI restraint/procedure including:
 - Special considerations (such as where and how, does the client cooperate by going to the floor on their own/)
 - ISP team rationale (including the guardian, if applicable) for the proposed PPI restraint/procedure
 - Brief history of past restraints/interventions and why they did not work (may include information about past injuries)
 - What happens if the client does not go into the restraint?
 - Safeguards that are in place for monitoring the client's safety in the PPI.
- ✓ This letter will need to be provided to the Behavioral Supports and Clinical Services Manager **1 week prior** to the Steering Committee presentation.



Step 2 Gather/develop the necessary documents of support:

- ✓ Redacted FA(if applicable) and BSP
- ✓ Behavior Data from the past year, including:
 - The number of PPIs (both program and emergency)
 - The duration of each PPI
- ✓ Documentation of the ISP Team approval of the Plan (i.e. ISP signature sheet, Discussion Record, Action Plan).
- ✓ These documents will need to be provided to the Behavioral Supports and Clinical Services Managers **1 week prior** to the Steering Committee presentation.

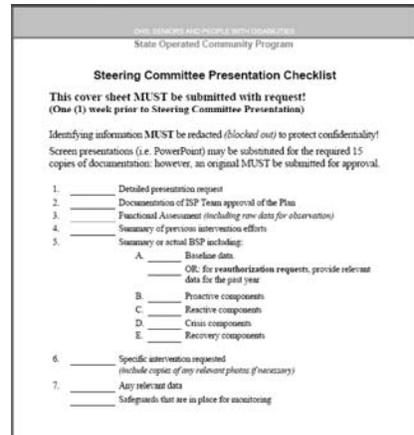
- ✓ Pictures (if needed) of the proposed PPI/procedure implemented by staff on staff
- ✓ Pictures of any special considerations (if applicable), such as the van if you are requesting a particular PPI in the van.

Step 3 Prepare for the presentation:

- ✓ Make 15 copies of the items outlined in steps 1 and 2 to be passed out at the meeting.
- ✓ Bring any reference material that you feel you may need to refer to as you answer questions from the Steering Committee.

Step 4 The Steering Committee presentation:

- ✓ Allow plenty of travel time so you arrive on time or early
- ✓ Take a deep breath and present the following information (10-15 minutes):
 - Pass out the copies
 - Pass out pictures (if applicable)
 - Client identifying information (i.e. age, gender, diagnosis)
 - **Do not provide the Client's name**
 - Brief behavioral history that is relevant to the proposed PPI
 - Brief history of past PPIs attempted for the behavior in question and the results
 - Brief description of the proposed PPI restraint/procedure and the ISP team's rationale



The image shows a document titled "Steering Committee Presentation Checklist" from the "State Operated Community Program". It includes instructions that the cover sheet must be submitted with the request one week prior to the presentation. It lists seven items to be included in the presentation, such as a detailed presentation request, ISP team approval, functional assessment, and summary of previous intervention efforts. It also includes sub-sections for baseline data, proactive/reactive/crisis/recovery components, and specific intervention requests.

Check SOCP BVS2 website for "Checklist" Tool – 1 week prior

If approved, the Steering Committee may provide a letter of approval, and/or they will stamp the copy of the BSP. The original letter/stamped BSP will need to be maintained in the individual's program book (with their BSPs) and a copy will be sent to the Behavioral Supports and Clinical Services Managers.

If the alternative PPI **is not** approved, then it cannot be written into the plan or trained to staff to perform on an "emergency" basis.

PPI's that require Steering Committee Approval must be renewed every year.

Section 8: Recovery strategies

This section details how to return the individual back to baseline and how to reintegrate individual back into normal daily activities.

BVS2: In particular, this section should describe methods to be used after a crisis that will help the person recover, regain balance and equilibrium and return to the supports described in the proactive strategies. The goal of this section is to support the individual's de-escalation and return them to a stable (baseline) state.

Section 9: Assessment summary

This section is the final section of the blended plan, and includes the following sub-heading:

BVS2: Summary of recommendations/revisions: In a narrative format, this section should address the following questions: Recommendations for further assessment or treatment (such as arousal assessment, psychological/neurological assessment), additions or discontinuance of challenging behaviors based on the behavior data summary, possible changes to BSP due to medical or psychiatric issues (including medication), changes to the BSP due to needs, preferences, and relationships, additions or discontinuance or alteration to special supports (including use of restraints, restrictions, media filters, removal of possessions, restitution used during past year), changes to BSP due to increasing or decreasing dangerousness of challenging behavior both in the home and the community, and a plan of follow up and a referral source for securing further assessment or treatment.

Final thoughts: How to Make a Peanut Butter and Jelly Sandwich and what does this have to do with writing a Behavior Support Plan?

Overview: With the hard work and innovation of the BVS2 team, SOCP's BSP have evolved over time. Changes included: combining the BSP with the Functional Assessment, making such items as "community restroom, vehicle, and general staff interaction guidelines" consistent components across all plans in SOCP, as well as, detailing how an individual's mental health and medical diagnoses impact their behaviors.

These revisions and others improved the overall functionality, readability and emphasizes the importance of clearly describing detailed procedures to facilitate staff's ability to effectively provide supports for the individuals within SOCP.

So, what does making a peanut butter and jelly sandwich have to do with any of this?

It is a teaching exercise. It starts by asking a group of individuals to write down instructions on how to make a peanut butter and jelly sandwich. These instructions are then read aloud and the individual in charge of making the sandwich follows the instructions—literally.

Okay, but: What does making a peanut butter and jelly sandwich have to do with writing a BSP?

SOCP BSP's are an example of expository writing, which is a form of written discourse that is used to explain, describe, give information or inform. This type of writing may be less creative, but it is incredibly important and useful. Expository text can not assume that the reader or listener has prior knowledge or prior understanding of the topic that is being discussed. In addition, expository text must use words that clearly show what is being described and provide enough detail so that the reader or listener can accurately follow the information provided.

Lessons to learn – take for instance the example on the next page:

An important skill for a Behavior Specialist to have is the ability to clearly communicate, in writing, the appropriate strategies needed to effectively support an individual. Moreover, they must provide enough detail so that these strategies can be duplicated in an effort to provide consistent supports. This applies to each section of the BSPs: Proactive, Reactive, Crisis, Recovery, etc.

Learning to write clear and concise **Behavior Support Plans** takes time and practice. Remember, the general characteristics of expository writing include:

- details, explanations, and examples
- strong organization
- ****clarity****
- unity and coherence
- logical order
- smooth transitions

****There is no more important element in writing than clarity. If a piece cannot be understood, it is of no value. If staff cannot understand the BSP, due to open-ended phrases, generalities, assumptions, or ambiguity, the plan will not be followed and the individuals supported (as well as staff) will be at risk.**

See Appendix page for a sample of a well presented/complete DHS 4588 Functional Assessment/ Behavior Support Plan (FA/BSP Blended Plan)

Literal vs. BSP directions for a peanut butter and jelly sandwich

Example	<u>Literal take vs. Examples of BSP Component/Parallel:</u>
1. Open the Bread	<p>Literal take: The instruction does not specify how to open the bread (e.g. untwist the twisty tie). So, one could just rip open the bag.</p> <p>BSP: Clarify open-ended instructions, such as: “terminate the outing/return the client home.” The question is HOW? When an individual is on an outing and there is a need to return an individual home due to behaviors, abruptly “terminating” the outing may actually place the individual and staff in potentially more dangerous situations. Perhaps other strategies, such as, making up a reason to return home (i.e. forget to get the cell phone), distraction (i.e. point out another place of interest, talk about something fun to do when get home) are a more functional way to “return a client home.” The key is to detail what these other strategies look like.</p>
2. Take out a piece of bread.	<p>Literal take: A piece implies a “part” of the whole slice. One could only take a small piece of the slice or everything but the crust.</p> <p>BSP: Elaborate and clarify what “validate an individual’s emotions, use active listening skills, problem solve, etc” really mean—specifically for the individual. Not everyone problem solves the same way. Not everyone knows off the top of their head what a validating statement is.</p>
3. Open the Peanut Butter	<p>Literal take: The instruction does not specify how to open the peanut butter. Perhaps one could smash it, jump on it, etc.</p> <p>BSP: Provide examples, or scripts. How do staff “cue someone to ‘stop?’” Remember most, if not all individuals do not enjoy being told “no.” In many cases, this can incite behavior. Provide a simple 3-4 word script for staff to follow when providing prompts (for both redirection and praise). For example, “John let’s get away from the fence and get dinner ready,” versus, “John, stop climbing the fence.”</p>
4. Spread Peanut Butter on the slice.	<p>Literal take: The instruction does not specify what I am to spread the peanut butter with. One could use their fingers, a stick, a spoon, etc;</p> <p>BSP: Pay close attention to potentially ambiguous or conflicting wording. If items are left open for interpretation, they have the potential for being implemented incorrectly</p>
5. Open Jelly	<p>Literal take: The instruction does not specify how to open the jelly. There are options here. One could smash it, jump on it, etc.</p>
6. Spread the jelly over the peanut butter	<p>Literal take: The instruction does not specify what I am to spread the jelly with. One could use their fingers, a stick, a spoon, etc; In addition, the instruction didn’t indicate an amount of jelly that is suppose to be spread. Is it the entire contents of the jar? A teaspoon?</p>
7. Put another slice on top	<p>Literal take: The instruction does not specify where the slice is to be placed on top of what. In addition, where is this other slice originally located? Is it from the existing loaf of bread? Another loaf?</p>

Formal behavior supports are not needed

What to do when the Team has determined formal Behavior Supports are not needed.

Overview: For some individuals supported by SOCP the team may determine that a Behavior Support Plan (BSP) does not need to be developed. This would be the case if the individual's dangerous behaviors can be alleviated through a change in either the way staff interacts with them and/or through changing the environment. In these instances, the BVS2 will need to develop either a **DHS 4588 Good Day Plan** or **DHS 4588 Staff Interaction Plan**. At a minimum, these documents need to be reviewed annually.

Note: For all clients supported at SOCP, they will either have a **4588 FA/BSP Blended Plan, DHS 4588 Good Day Plan** or **DHS 4588 Interaction Plan** depending on their level of support needs. In addition, the Good Day Plan is considered a document of support and needs to be listed on the ISP Risk Page.

DHS 4588 Good Day Plan

In general, a Good Day Plan will be developed for individual's who meet the following criteria:

1. Behavioral risks have been identified (i.e. one or more of the RTR questions #50-67 are marked "yes.").
2. Behavioral risks, though identified do not present a serious or significant risk to the individual and/or others (i.e. they are very low in frequency/intensity/severity), however supports are needed to prevent the identified behavior.
3. Behavioral risks can primarily be alleviated through a change in either the way that staff interacts with the individual and/or through environmental modifications.

DHS 4588 Good Day Plan

The components of a Good Day Plan are similar to those included in the Blended Plan (See "Putting it all Together: The Blended Plan"), and are as follows:

Section 1: Client Profile - The content is the same as the Blended Plan.

Section 2: Needs, Preferences, Relationships and Communication - The content is the same as the Blended Plan.

Section 3: Behavior definitions - This section covers the following: Behavior definitions (for both behaviors to increase and decrease), Setting Events, Triggers, and Precursors for each behavior(s), data collection methods, as well as Alteration Criteria. This section is organized in a table format.

BVS2: Depending on the individual, they may or may not have functional alternatives (i.e. behaviors to increase). In other cases, the individual may have functional alternatives, however formal data collection is not being pursued. This may be due to such factors as:

1. An individual's mental health and/or physical condition(s) have a pervasive impact on their capacity to participate in learning/practicing the behaviors to increase (e.g. they may have dementia, severe autism, failing health, etc.).
2. An individual may participate in a functional alternative (e.g. problem solving) on a daily basis and it has proven to be a successful strategy for the de-escalation of behaviors. In addition, the team has determined that new functional alternatives are not necessary at this point in time.

Section 4: Behavior functions - The content is the same as the Blended Plan.

Section 5: Proactive strategies - The content is the same as the Blended Plan.

Section 6: Reactive strategies - The content is the same as the Blended Plan.

Section 7: Crisis strategies - **BVS2:** In most cases, a Good Day Plan will not have a Crisis Section. For most Good Day Plans, the only PPI's that are utilized will be on an emergency basis. In some cases, the only approved PPI's will be body positioning and a belt-shirt (all variations). If more restrictive PPI's are needed, the team may want to consider developing a BSP for the client.

1. If there are no authorized PPI's for the individual, this section should detail why this is (e.g. medical/health reasons, none needed) and that any PPI would be considered an emergency PPI.
 - a. This section will also include the heading "When to Abort the PPI." This will need to be phrased as follows:
 - **Should it become necessary to implement an emergency PPI** with client, staff should abort a PPI any time that it becomes unsafe to maintain the PPI for either client or the Staff. Staff should abort if they are no longer able to physically manage client in the PPI. Staff should abort if the PPI is placing client at risk for harm (i.e. making it difficult for her to breathe, cutting off circulation, etc...). Staff should also abort the PPI if client manages to move into a position unapproved by OIS (i.e. client slides down the wall and into a prone position). When aborting a PPI make sure that you are communicating with your co-workers and that you all release together if possible.
2. If there are authorized PPI's for the individual, the BVS2 will proceed with the instructions laid out in the "blended plan" format.

Section 8: Recovery Strategies - The content is the same as the Blended Plan.

Section 9: Assessment Summary - The content is the same as the Blended Plan.

See Appendix(es) for completed samples of the DHS 4588: FA/BSP Blended Plan, Good Day Plan and Interaction Guidelines.

will document this in the “Team discussion / recommendations” section. An action plan will be developed as outlined in step #2.

Note: *Though the 4588 Interaction Guidelines will not be listed on the ISP Risk Page, it will require a change form for any revisions throughout the individual’s ISP year.*

The components of **Interaction Guidelines** are similar to those included in the **FA/BSP Blended Plan** (See “Putting it all Together: The Blended Plan”) and the **Good Day Plan** and are as follows:

Section 1: Client profile - The content is the same as the Blended Plan.

Section 2: Staff guidelines - This section details what staff need to know in order to effectively interact with the individual to promote a successful day, as well as, to increase the individual’s quality of life.

Though this section has the potential to have several sub-headings, the following must always be addressed for each individual:

1. **Supervision levels (general):** This section will address the general supervision levels that an individual may require in order to maintain their and other’s health and safety. This section is organized in a table format and covers the following supervision areas:
 - a. **Awake:** Bedroom, Asleep: Bedroom, Bathroom, Kitchen, Living/Dining Room, Laundry Room, Yard, Stores, Parks, Restaurants, and Crowded Community Events (e.g. fairs, dances, etc.).
2. **Supervision levels (other):** This section will address any “other” areas that may apply to a particular individual. This section is also organized in a table format, however the table does not have to be utilized if it does not apply (i.e. it can be deleted and/or replaced with narrative). This section can cover a variety of areas, including, but not limited to the following: Special Olympics/Sporting Events, Dances, and/or Special considerations (e.g. 2:1 in the community).

Note: *Clients whose ISPs occurred prior to June 1st, 2010 will have supervision levels detailed in a document titled “Staffing Expectations.” This document will remain valid (i.e. will need to be updated and trained) until the individual’s new ISP. After June 1st, 2010, all client supervision levels will only be included in the BSP as outlined above.*

3. **Communication grid:** This is a grid that identifies the following:
 - **When client does/says this:** This is any form of communication/behavior that the client has been observed participating in;
 - **We think that it means this:** This details what the team thinks the client is trying to communicate/convey when they participate in the identified behavior/activity
 - **Staff should respond by:** This is a guide as to how staff need to respond/interact with the individual.

Note: *Interaction guidelines do not address Reactive, Crisis, Recovery or Assessment Summary sections. If this is needed, the team may want to consider the employment of a Good Day Plan or FA/BSP.*

Pre-meeting and agenda

Overview: The Pre-meeting is a required face-to-face meeting between the Residential provider and Employment/ATE provider with the exception for children and individuals without an Employment/ATE provider. This meeting creates the PFW; creates, reviews, and/or updates the RTR; and drafts the agenda.

The Agenda is the required tool used by ISP teams to record all the issues and topics that they must address at the ISP meeting. The purpose of the **Agenda** is to make meetings more effective and efficient, using the **Personal Focus Worksheet** and the **Risk Tracking Record** to help identify all issues the team wants to discuss. The Services Coordinator/Residential Specialist, or designee, must receive a copy of the agenda prior to the ISP meeting in order to effectively facilitate the meeting.

This meeting looks at each PFW written for the person and, then, either compiles it into one document or they are stapled together to create one document. The agenda questions on the PFW are answered. The RTR is either created, reviewed, or updated together. After the RTR has been completed, Section Three of the agenda is drafted for the team.

The Agenda has specific topics to address:

Question One directs the team to review the ISP from the previous year and address any areas that may need further attention. This does not require word for word reading of the ISP, just a review. At the ISP meeting or the Pre-Meeting, briefly write the items to continue from last year onto the agenda. This section helps look at planning as a continuous process.

Question Two directs the team to review the newly drafted ISP ages to ensure that the information is current and correct. The pages may be modified at the meeting as needed.

Question Three directs the required team members to review the PFW and RTR and document the Discussion Topics. Those team members also collect and record topics from the individual and/or other team members. This information has an outline for the Discussion Topics required. One of these directives is 'Items for Consideration' that if answered 'Yes' must be included on the Agenda under Discussion Topics. If a person does not wish an item to be discussed at his/her meeting, omit it from the agenda. The team will have to arrange another method to address that item but not in the person's ISP meeting.

The column labeled "Action Taken" is filled in at the ISP meeting. If Information is resolved at the Pre-Meeting and is a required agenda topic, it must be listed under Discussion Topic and, in the Action Taken column, write "issue resolved at Pre-Meeting" or "issue resolved on (date completed)." While at the ISP meeting, if an agenda Discussion Topic cannot be addressed during that ISP year, the team may write "deferred until next ISP year." When an item is deferred, it needs to be addressed as indicated on the agenda. Other Action Taken could be "Discussion Record," "Action

Plan” or “Support Document created.” The ISP team will determine the information written in Action Taken and it must be completed for each Discussion Topic.

BVS2: Overall, the Behavioral Specialist’s role during the Pre-Meeting is as follows:

1. Work as a team to review, create or update the RTR (specifically, questions #50-67).
2. Ensure that the identified Risks match those determined throughout the FA process (i.e. marking “yes” for those that are/should be tracked; marking “no” for those that should not be tracked, or marking “history” for those risks that have been identified as such).
3. Use the opportunity to bring up any changes to the behavioral supports prompted by the FA process. For example, if during the FA process the Behavioral Specialist determined that the function of a particular behavior was a means to communicate (generally speaking), the Pre-Meeting could be a medium for discussing the introduction of new communicative functional alternatives (e.g. picture board, sign language, etc;).

Making Changes

Overview: Changes are inevitable and making them in a timely fashion is critical. Any changes, additions, or deletions to Support Documents listed on the ISP Risks page or to any pages of the ISP must be recorded on the Change Form.

Oregon Technical Assistance Corporation (OTAC) Change Form:

CHANGE FORM		
Person receiving services: Client Name		Date of change: When actually happens
Indicate which document(s) you are changing, adding, or discontinuing:		
<input type="checkbox"/> Individual Support Plan <input type="checkbox"/> Safety Plan <input type="checkbox"/> Financial Plan <input type="checkbox"/> Protocol, <input checked="" type="checkbox"/> Other Document,		
title:		title: FA/BSP
Reason for Change	List Specific Change(s)	Where is the change documented?
Update FA/BSP to better support needs of the (Client name)	Revised Reactive Strategies to include providing verbal cues. Added media protocol. Removed the tracking of extreme food seeking; proactive guidelines will remain.	FA/BSP ISP Risk Page will also need to be updated as the date of the FA/BSP will be changing. Risk page will also need to be updated if behaviors are added/removed. Also update Monthly Summary if behaviors (functional alternatives and/or challenging behaviors) have been added/removed.
Signature of the person initiating change: BVS2 Signature		
Date sent to CDDP Services Coordinator/ODDS Residential Specialist:		

BVS2: Completing the Change Form

Write the name of the person receiving services and the date the change will be implemented.

Indicate by checking a box(es) next to the document being changed.

- Changes made to the BSP will be checked under “Other,” and then labeled as FA/BSP: this is the blended plan.
- Changes to the **Good Day Plan/Interaction Guidelines** will also be marked under “other.”

Under “Reason for Change,” write the reason for changing the above document such as, “Updated BSP to reflect current support needs of individual,” or “Updated BSP to reflect move to new home ____.”

Under “List Specific Changes,” be specific to each change and why the information was added, changed, modified, or discontinued. For example, 1. Modified the staff interaction guidelines to include vehicle guidelines, 2. Revised Staffing Levels, 3. Removed media guidelines.

Note: *More than one type of change can occur per **Change Form**. If changing a protocol or other document, write the specific title of the protocol or document.*

Under “Where is the change documented,” include the FA/BSP (blended plan), ISP risk page, Good Day Plan, Interaction Guidelines, Staffing Expectations and/or any other relevant behavioral support documents.

The person initiating the change signs the front page. The date the change was sent to the Case Manager must be recorded below this signature.

Contact the required team members as noted on the ISP Signature page for approval of the change(s). All ISP team members’ names must be listed on the Change Form Approval Page.

If no signatures are required, document how the approval was obtained such as “by phone” in the signature box and in the date box, write the date the approval was given. Please note that leaving a telephone message for a team member does not constitute receiving his/her approval unless noted under “Exceptions” on the ISP Signature page.

If signatures are required by the ISP team, circulate the **Change Form** with the Change Form Approval Page and any needed attachments to the indicated team members for approval, signatures and date of approval. Objections to the change should be noted, if any were voiced, in the box provided.

Note: *Changes to any support document cannot be implemented until the required team members have been contacted and approval has been obtained (whether that be written, email, phone, etc.). This includes the Person Receiving Services:*

The ISP team must also consider whether they believe the person understands the contents of the changes. If the person is unable to sign or make a mark, or if the team believes the person does not understand the changes, the team must follow the instructions below.

How to document the person’s understanding and approval of the changes when the individual:

- a. Does not understand the changes and may/may not be able to make a mark.

- The team and the Services Coordinator/Residential Specialist review the changes to ensure that it captures the person’s support needs and preferences.
 - There would be no signature in the space provided for the person receiving services, but a note at the bottom of the change form indicating “unable to sign, team agrees that the individual does not understand the changes.”
- b. Does understand the changes but is physically unable to produce a signature or other personal mark.
- There would be no signature in the space provided for the person receiving services, but a note at the bottom of the change form indicating, “Understands the changes but is unable to sign.”
- c. Does understand the ISP and uses a mark as their signature.
- The person’s mark must be witnessed and documented on the change form Signature page.
 - An ISP team member (may be the BVS2) must indicate near the mark: “witnessed by_____.”

Providers keep original Support Documents. Be sure only the most current copy is available to staff. A copy of any revised Support Document must be sent to the Case Manager.

Keep completed **Change Forms** with the ISP.



Bring blank Change Forms to individual ISPs, Monthlies, and Needs/Relocation meetings. By doing so, if changes come up, you can immediately complete the change form, gain the ISP team’s approval and signatures. In this way, you can make changes to the FA/BSP (Good Day Plan or Interaction Guidelines) in a timely manner, without having to wait for initial approval.



Remember if an ISP needs to be extended past the month of the ISP end date, ISP team signatures are required to extend the ISP even if ‘phone approvals’ were indicated for changes. If an ISP will begin before the month of the end date, no Change Form is needed.

Summary: Key points to remember about **Change Forms**:

1. Changes cannot be implemented until **all the members** of the ISP team have provided their approval (via signature, email, fax or phone). Given this, the actual date of the change needs to coincide with the date that this approval has been received. For example, if 3 of the ISP team members provided signature approval of a change to the FA/BSP on 4/1, and the final 2 provided approval on 4/8 the date of the change must be on or after 4/8.
2. The Behavior Specialist cannot begin training any changes to the FA/BSP or other support document until after the date that the change was made (and all members of the ISP team have provided their approval of the change). For example, if the date of change on the change form is marked as 4/10, training cannot begin on 4/2.

3. **Any change** made to the FA/BSP requires a change form. This includes such changes as those made to the alteration criteria, data collection, etc.
4. Changes that happen throughout the year **do not** need to be trained by the “end of the month.” This only applies to the annual ISP. For example if an individual’s ISP is in May and changes are made to the FA/BSP on 2/23, these changes **do not** need to be trained by the end of February. Rather changes to support documents during an individual’s ISP year (e.g. ISP protocols, FA/BSP, Staffing Expectations, etc.) need to **be completed within 30 days of receiving team approval.**
 - a. Some changes to support documents will need to be trained prior to the general 30-day rule above. For instance, changes that impact the health and safety of a client (e.g. moving from 1:1 staffing to 2:1 staffing, addition/removal of media guidelines, addition/removal of particular maladaptive behaviors) will need to be trained within 2 weeks of team approval. The goal should be to provide the training to the majority of the staff within this timeframe. Raw Data Sheets, Incident Report and Progress Notes Review

Overview: In order to effectively assess and understand issues regarding an individual’s problem and positive behaviors, it is necessary to review raw data sheets, progress notes, and Incident Reports (IR). Such a review will facilitate the ability to evaluate options, form accurate conclusions, and make informed decisions regarding an individual’s current and/or future behavioral support needs.

BVS2: At least 3 times in a workweek, review the raw data sheets and **DHS 4596 Progress Notes** for completeness and accuracy, and as a reliability check on information.



Date	Time	
1/5/06	3:45 p.m.	Always fill in the date you are making the entry. If you are making a late entry, you should write "Late entry for 10/4/06" (for example) at the beginning of the entry. The time column should be filled in consistent with the way your house is recording time using military or standard time. -----M. Howard CT
1/5/06	3:45 p.m.	Always finish your entry with your signature, which should include a first initial/last name (e.g. HTT2, MHT2, BSVC, SM, etc.). If there is space between the end of your entry and your signature, be sure to draw one line to the end of the line to assure no information is filled in any blank spaces. -----M. Howard CT
1/5/06	3:45 p.m.	Always make your entries legible. If necessary, print instead of using cursive writing. Use only blue or black ink. NEVER use white out when making corrections. If an error is made, draw one line through the error and initial at the end of the error line. -----M. Howard CT
1/5/06	3:45 p.m.	Always write objectively the facts and not subjectively your feelings. Do not diagnose but be descriptive of the situation you are documenting. For example, don't write "he seems depressed." Rather document "he has been sleeping during the day, which is unusual, up to 3 hours at a time, while sleeping intermittently at night. I have observed this for the past two weeks." He is also not eating all of the meals he is offered, which is also unusual. His mother told him last week (entry dated 12/24/05) that she has been very sick so he cannot come home for his regular visit. -----M. Howard CT
1/5/06	3:45 p.m.	If you are documenting information for which you are also completing an Incident Report, do not write in the progress notes that "an IR was completed." It is not necessary to rehash all the details twice if you are completing an IR. Put the details on the IR and a brief summary as needed in the progress notes. -----M. Howard CT
1/5/06	3:45 p.m.	When you need to continue an entry onto the next page, you must write "continued next page" at the bottom of one page and top of the continuation page (continued from the previous page). -----M. Howard CT
1/5/06	3:45 p.m.	When there has been a documented injury that does not have medical treatment (eg. a bruise) daily follow-up must occur in the Progress Notes, checking and documenting until someone writes specifically that the issue is resolved. When you are documenting on the back of the MAR from a treatment, you only need to write a note in the Progress Notes when you find the injury and consider it resolved. -----M. Howard CT
1/5/06	3:45 p.m.	Follow the house policy related to the frequency of the daily follow-up checks and related documentation. Some issues are done each shift, while others may be only need to be done once a day. -----M. Howard CT
1/5/06	3:45 p.m.	If medication does not arrive from the pharmacy, at the anticipated arrival time and was not dispensed, make a note in the Progress Notes. When it does arrive make a follow-up entry (Continued on the following page). -----M. Howard CT

Client receiving services: _____
Policy #4 007 Attachment A. Mandatory DHS 4596 (06/08)

Date	Time	
1/5/06	3:45 p.m.	(Continued from the previous page) and document per procedure on the MAR, FAR, -----M. Howard CT
1/5/06	3:45 p.m.	When side effects of medication are noticed with an individual the observations should be documented in the Progress Notes. The Site Manager should be notified. -----M. Howard CT
1/5/06	3:45 p.m.	Think in terms of "exceptions" rather than normal, when doing medical documentation. Instead of writing "seems to feel good today" or "no medical changes," note the exceptional medical issue like "noticing a pattern of sleeping more over the past three days-- from 10pm - 1 pm all three days" or "itchy area that is usually about the size of a quarter on right forearm is 3 inches today." -----M. Howard CT
1/5/06	3:45 p.m.	You cannot make a change to another person's entry in any situation. If an error has been made or additional information is needed, you must make your own entry. For example, "Note of 1/5/06 3:45 pm indicated that Joe's left knee was scraped but it is his right knee." -----M. Howard CT
1/5/06	3:45 p.m.	If you are in a situation where an individual wishes to file a grievance or complaint, a note should be made in the Progress Note. If you have a complaint (these are usually resolved informally), make a note indicating the concern and what your resolution was. If you have a formal grievance, include in your note what the date is that you gave it to the Site Manager to begin the resolution process. -----M. Howard CT

Client receiving services: _____
Policy #4 007 Attachment A. Mandatory DHS 4596 (06/08)

Incident Reports: Though it is important to review all relevant Incident reports, it is also the responsibility of the Behavioral Specialists to provide a brief commentary on the reports **only when a program or emergency PPI have been utilized as a part of the staff’s response.**

This written review will be provided directly on the Incident Report form and should include the following:

IR 4595

IR 4595A

IR 4595B

IR 4595C

- 1) An assessment as to whether the PPI was authorized by the individual's current FA/BSP
- 2) An assessment as to whether the PPI was necessary (e.g. were the current Proactive and Reactive strategies of the FA/BSP followed/implemented prior to the use of the PPI?)
- 3) An assessment as to whether the length of the PPI was appropriate for the behavior.
- 4) An assessment addressing whether or not the number of PPI's in a given month has increased/decreased.
 - a) When assessing the number and length of an individual's PPI, consider the following:
 - Was the length of time that a client was in a PPI **only as long as was essential to protect the client and/or others?**
 - Was the degree of the physical intervention in proportion to the circumstances and the potential outcomes if the intervention was not utilized (e.g. it would be a misuse of a PPI to physically intervene when a client is engaging in verbal aggression).
- 5) Any need for follow-up (e.g. training, clarification, changes to the FA/BSP)?
 - a) If there is follow-up (e.g. training) the BVS2 must ensure that there is documentation of this follow-up (e.g. a training record).



In order to make an accurate assessment, it may be necessary to consult the **Progress Note** entries and/or to interview the staff involved.

Summary: The following timelines will be used for processing Incident Reports (IR's):

The case manager will be notified of the incident by fax or telephone. The incident report will be completed before the end of the shift on which the incident occurs.

The Site Manager will assure the Incident Report is reviewed within 3 working days of the occurrence, and forwarded to the Program Manager.

Note: *Given this timeline, the BVS2 will want to ensure that they are checking the Incident reports on a daily basis to identify incidents that require their review within the 3 day timeline.*

If Incident Reports, Raw Data Sheets, or Progress Notes are incomplete, the staff and Site Manager will need to be notified to either complete or revise their documentation.



State Operated Community Program
Incident Report (IR) Part 1

CORE IR#

Residential or Vocational

Home or Community

Name: Smith, Joe (Last) (First)

Date Incident Occurred: 11/14/08

Time Incident Occurred: 0915

House Name: Adell

Date Report Initiated: 11/14/08

A) What happened before the incident? 'Before' doesn't necessarily mean immediately. Think about about interactions with others over hours, shifts, or days. Consider outings and locations where a person might have come in contact with branches or hard edges. Look at how they have been sleeping (or not), have they appeared more lethargic or active than usual. Read 'Progress Notes' to see if others have noticed changes, etc. Was your individual in a 'Protective Physical Intervention' (restraint)?

B) What happened during the incident? Think about what actually happened at the moment of the incident. If this is an injury that you didn't see happen, your research in the previous section is even more important to possibly understanding why the person has a bruise or scratch, etc. If the individual reported what happened, make sure your writing clearly indicates this is what the person said. Use 'quote marks' if appropriate.

C) What intervention did you do? Following Dr.'s orders, calling doctor, going to the emergency room, moving a sharp object ...etc. Be sure you are checking the environment for safety hazards if that is a probable cause and whenever possible fix or secure it in some way so others aren't injured. Called 911, went to emergency room ... be thorough.

D) What resulted from intervention? If you are documenting a behavior event, and you don't see an injury right now, did something happen that might result in an injury tomorrow? Be thorough in your thinking. If there were no ongoing issues after you did your first aide, make a statement to that effect. Everything went well at ER with new orders, etc.

Other staff involved: none

Name and title of person completing IR: M. Howard, HTT2

Notification:

Guardian/Parent/n/a: Date: Time: Fax Phone Delivery In Person
Service Coordinator: Date: Time: Fax Phone Delivery In Person
Site Manager: Date: Time: Fax Phone Delivery In Person
Program Manager Date: Time: Fax Phone Delivery In Person

Distribution: Original - SOCP Central Office; Canary Copy - House, Pink Copy - Client Files

Incident Report (IR) Part 2

Name: _____ Date: _____ Time: _____
(Last) (First)

Protective physical intervention (PPI) Emergency protective physical intervention Emergency psychotropic medication

Program administration authorization: Yes No Time notified: _____

Program Administrator name: _____ Time approved: _____

List Protective Physical Intervention (PPI) used:

Type of PPI? _____	Type of PPI? _____
How long was person in PPI? Min: ____ Secs: ____	How long was person in PPI? Min: ____ Secs: ____
Staff administering PPI? _____	Staff administering PPI? _____

Type of PPI? _____	Type of PPI? _____
How long was person in PPI? Min: ____ Secs: ____	How long was person in PPI? Min: ____ Secs: ____
Staff administering PPI? _____	Staff administering PPI? _____

Type of PPI? _____	Type of PPI? _____
How long was person in PPI? Min: ____ Secs: ____	How long was person in PPI? Min: ____ Secs: ____
Staff administering PPI? _____	Staff administering PPI? _____

Behavior Specialist signature: _____ Date: _____

Did an injury occur? Yes No

Type of injury: _____ Location of injury: _____ Size: (inches) _____

Treatment _____

How should the incident be classified: (check all that apply)

<input type="checkbox"/> Death	<input type="checkbox"/> Suicide	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Self-injury	<input type="checkbox"/> Aggression
<input type="checkbox"/> Illness	<input type="checkbox"/> Attempt	<input type="checkbox"/> Prop.destruction	<input type="checkbox"/> Non-edible objects	<input type="checkbox"/> Referred for (OIT) investigation
<input type="checkbox"/> Medical	<input type="checkbox"/> Threat	<input type="checkbox"/> Emergency PPI	<input type="checkbox"/> Incident w/public	<input type="checkbox"/> Missing
<input type="checkbox"/> Police	<input type="checkbox"/> Choking	<input type="checkbox"/> Program PPI (approved in BSP)		
<input type="checkbox"/> Fire	<input type="checkbox"/> Injury	<input type="checkbox"/> Emergency psychotropic medication		
<input type="checkbox"/> Other: _____				

Distribution: Original (White) – SOCP Central Office
OAR 411-325-0190; 411-345-0230 Mandatory

Canary Copy – House
Page 2 of 5

Pink Copy – Client files
DHS 4595A (06/10)

8. **Length of time in each PPI (Emergency and program PPI):** This information can be gleaned from the Incident Reports.
9. **Tracking of psych medication changes:** This information can be found on the Psychotropic Drug Record and/or MAR.
10. **PRN psychotropic med:** This is relevant for any individual who has a PRN psychotropic medication.
11. **DHS 4554 Balancing Test:** All medications prescribed for an individual's mental health diagnosis need to be listed here, as well as when their next balancing test is due (these are due annually).
12. **Comments from the behavior review:** This section is used to provide information on the previous month concerning the individual's behaviors, including, but not limited to the following:
 - a. In general, the stability, instability of behaviors
 - b. Any contributing factors to an increase/decrease in behaviors (e.g. medications, transfers, getting a new roommate, family issues, job loss/gain, changes to BSP supports, etc.)
 - c. If the individual met alteration criteria and follow-up plan (e.g. change behavioral supports, re-define the at risk behavior, etc.)
 - d. Possible changes/action plans to revise the BSP due to any of the above
 - e. If applicable, an explanation of any missing data.
 - f. Review of PPI's, including length of time. For example, if an individual's total number of minutes in a PPI has increased, provide an explanation and review with the team if any changes need to be made to the plan. Or, if an individual was in a PPI for a particular behavior for an extended period of time, provide an explanation and review with the team if any changes need to be made to the plan and/or if re-training needs to be pursued.

When assessing the number and length an individual's PPI consider the following:

- Was the length of time that a client was in a PPI **only as long as was essential to protect the client and/or others?**
- Was the degree of the physical intervention in proportion to the circumstances of the incident and the potential outcomes if the intervention was not utilized (e.g. it would be a misuse of a PPI to physically intervene when a client is engaging in verbal aggression).

13. Date and brief summary of incident reports: Provide a brief summary of all incident reports.

Summary: Key points to remember about the monthly reviews:

- Take full advantage of the monthlies. Use it as a time to discuss ideas about changes to the current behavioral supports, such as: additions/discontinuations, opportunities to run baselines on new supports with the intent to report back to determine if these should be included in the FA/BSP, etc.

- Bring blank **Change Forms** in anticipation of any changes that may be discussed at the meeting. In this way, you can gain team approval and signatures immediately. This will assist in the process of getting changes approved/completed/trained in a timely and effective manner.
- Any changes that you make to the **FA/BSP** (e.g. addition/discontinuance of tracked behaviors, changes to alteration criteria) needs to be reflected in the next relevant monthly (after the change has been approved, trained and implemented). For example, if at the April monthly meeting it is decided to discontinuing tracking “Physical Aggression” for an individual and the change form is completed and signed at the meeting, then the training and implementation is completed in May, the monthly for June will need to be revised.

Psychiatric appointments

Overview: Individuals, who are on any kind of psychotropic medication, will have a relationship with a psychiatrist. Typically, an individual will see their psychiatric provider every 3 months.

BVS2: How to prepare, conduct and follow-through with client psychiatric appointments

Items needed for the Psychiatric Appointment

1) Updated PVO(DHS 4576 Physician's Visit/Orders)

- a) Compare existing PVO to MARs and TARs
- b) Ensure that diagnosis, medications (including PRNs), treatments, diet, allergies, etc; are current and match across documents.

2) Blank addendum

- a) Bring in the event that the Psychiatrist prescribes new medication/dosage.
- b) Remember that the addendum must match exactly with the orders on the original physician order's form.

3) DHS 4554 Balancing test(s)

- a) These need to be updated (signed) every year.
 - i) Bring current balancing tests for medications that need to be updated for the year.
- b) Bring a blank balancing test, in the event that the Psychiatrist prescribes a new medication.

4) Copies of Behavior graphs

5) Copies of 2 year (or yearly) behavior data

- a) If none exists, utilize data from the most recent monthly.

6) Copies of Sleep data, if applicable.

7) Residential book.

- a) Bring to review progress notes, as well as, to have easy access to client's health cards.

8) Paper and pen to take diligent notes.

Preparing one's self for the Appointment

1) Familiarize self with the individual's medication(s)

- a) Understand purpose, average dose, side effects
- b) Utilize the Pill Book Guide to Prescription and Nonprescription Drugs.
- c) Utilize credible websites that end in ".org," or ".gov," such as: www.nlm.nih.gov (Medline Plus website).
- d) Websites ending in ".com," are typically not as credible.

- 2) Review progress notes, behavior data and notes from prior appointments.**
 - a) Look for trends in behavior: Has an individual's behavior increased/decreased? What factors contributed to the increase/decrease? Is it environmental (e.g. staff changes; moves; new housemates; season changes; changes in needs/preferences/relationships; illness?) Is it due to increases/decreases in medication? New medications?
 - b) Compare information with what you know about the individual's current medications. Are the medications supporting the individual in reducing their behaviors? Are the side effects impacting an individual's behaviors?

- 3) Compile items that you want to discuss with the psychiatrist.**
 - a) Behavior trends – Consolidate behavior onto 2 yr graph format
 - b) Sleep data (if applicable) – Consolidate onto graph format
 - c) Mood Chart (if applicable) – Consolidate onto graph format
 - d) Summarize unusual Incident Reports
 - e) Impact of medication and side effects on behavior
 - f) Pursuing new medication/doses
 - g) Prepare team recommendations – research Internet/DSM

What to do at the Appointment

- 1) Present self professionally**
 - a) Have everything ready for the psychiatrist to review/sign
 - b) Have questions ready
 - c) Be knowledgeable of client's medications/behavior trends
 - d) Take notes

- 2) Don't be defensive or confrontational**
 - a) Ask questions and provide information in a professional manner

- 3) If a new medication is prescribed:**
 - a) Ask why there is a need for a new med, what it will do for the individual, and what the overall goal is (e.g. decrease behaviors, side effects, etc;).

- 4) Encourage the individual to participate and ask questions.**

What to do for Intake Appointments when an individual retains a new psychiatrist

- 1) Prepare a Client History packet for the new psychiatrist**
 - a) Cover letter that discusses the basic history of the client and their behavior trends—
Include a table of contents:
 - b) Most recent psychiatric evaluation
 - c) Psychotropic drug record
 - d) 2 year behavior data
 - e) Most recent monthly
 - f) Sleep data (if applicable)
 - g) ISP, FA/BSP, PFW

- 2) Send the **Client History** packet to the new psychiatrist at least a week in advance of the intake meeting. The packet will help to guide the appointment.

What to do after an appointment

- 1) If there are medication/dosage changes, the individual taking the client to the appointment will transcribe on the MAR the appropriate changes, and notify the pharmacy (e.g. fax over new **DHS 4576 Physician Visit Order PVO**).
- 2) Document any new/changes in medications on the **DHS 4629 Daily Log** so all staff are aware and can follow-up on side effects, etc.
 - a) If there are any new/changes in medications be sure to update the **PVO** as necessary for the next physician's visit.
- 3) Complete the Staff information section on the **PVO**
 - a) Include how the client responded
 - b) Med changes
 - c) Recommendations
 - d) Next appointment
 - e) Whether new orders have been faxed to the pharmacy

The image shows a thumbnail of the DHS 4576 Physician's Visit/Orders (PVO) form. It includes fields for Client Name, Date, Name of Physician, Other Specialist, Reason for Visit, Current Medication/Treatments, Oral Medication, Treatment Medication, PRN Medication/Treatment, Prosthetics, Special Diets, Known Allergies/Adverse Drug Reactions, Psychiatric Diagnosis, Significant Findings of Examination, and Physician's Orders. The form is labeled 'DHS 4576' at the bottom right.

The image displays two pages of the DHS 4576 Physician's Visit/Orders (PVO) form for client Wasty Jesus, dated 11/19/08. The form is filled out with specific medical information.

Page 1 (Left):

- Client Name: Wasty Jesus Date: 11/19/08
- Name of Physician: Dr. Fivell Other Specialist: _____
- Reason for Visit: Annual Exam
- Current Medication/Treatments – Dosage and Time
- Oral Medication:
 - Artane 2 mg. 2 tabs po q am
 - Artane 2 mg. 1 tab po tid
 - Resperal 2 mg. 1 tab po tid
- Treatment Medication: None
- PRN Medication/Treatment:
 - Tinzolin Powder apply PRN to feet for complaints of itching, no more than every 6 hours until itching subsides.
 - Acetaminophen 325 mg 2 tabs po every 4 hours as needed for pain or temp over 100°.
- Prosthetics: None
- Special Diets: None
- Known Allergies/Adverse Drug Reactions: None
- Psychiatric Diagnosis: Mental Retardation / Schizoaffective disorder
- Significant Findings of Examination: Eyes are normally dry. Noticed increased shaking of Wasty's hands.

Page 2 (Right):

- Physician's Orders (Medication, Treatment, Revisions, etc.)
 - Visions 1-3 drops in each eye BID x 5 days.
 - Increase Artane to 5 mg 1 tab po BID.
 - Return in two weeks to recheck eyes.
- Attention Physician: Please state time period for all orders (ie. take until gone, use until rash disappears, etc.)
- Pharmacy: Oak Phone: 503-555-1234 Fax #: 503-555-5678
- Physician's Signature: Dr. Fivell Date: 11/19/08
- Staff Information
- Staff Signature: _____ Date: _____

- 4) Make a **DHS 4596 Progress Note** entry
 - a) Entry does not need to match the information from the staff information section on the **DHS 4576 PVO**. Can simply indicate that the individual had a psychiatric appointment.
 - b) Can be more detailed than the **PVO**
- 5) Write next appointment on house calendar
- 6) File in client's **Residential Book**.

Training

Overview: As a part of the current Behavior Specialist job duties you will be involved in training staff, (as well as Site Managers and Vocational Specialists, as appropriate). Things to keep in mind when training:

1. Utilize an array of training techniques
2. Adapt the training to the trainee's learning style
3. Develop a rapport with trainees
4. Work to effectively communicate and convey the information for the purpose of having others learn, understand, and apply the information
5. Whenever possible, make every effort to assure that the learning environment is free from disruptions and distractions
6. Provide opportunities for clarifying questions and/or answers
7. Assure that the length of time for the training is appropriate for the items covered

BVS2: Training responsibilities:

<http://www.dhs.state.or.us/spd/tools/dd/socp/inhouse-trn-duties.pdf>

Core Competencies: Train to new employees, including before they work unassisted. Employees who have completed the Core Competencies, (Before Working Unassisted, Within 30 and 90 Days), upon transferring into another home must receive **Transfer** training using the **Transfer Core Competency (blue form)** before working unassisted in the home.

State Operational Community Program Core Competency Demonstrations In Home Training		Competency	Demonstration	Ass	WU	W30	W90
Before working unassisted							
SAFETY							
S1	Learn emergency notification procedures including ways to be advised of an emergency, how and where to call.	When presented with hypothetical emergency scenarios, will demonstrate proper and safe behavior as individual.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
S2	Follow personal emergency evacuation procedures.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
S3	Recognize emergency situations and report and/or notify appropriate personnel.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
S4	Learn when equipment requires repair or replacement.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
HEALTH							
H1	Learn when to administer first aid to a person.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
H2	Recognize signs and symptoms of common medical conditions.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
H3	Recognize signs and symptoms of common mental health conditions.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
H4	Recognize signs and symptoms of common behavioral health conditions.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
Within 30 days of hire Competency completed during NED OIE instruction. (See Core Competency NED Assessment)							

State Operational Community Program Core Competency Demonstrations In Home Training		Competency	Demonstration	Ass	WU	W30	W90
Within 3 months of hire:							
SAFETY							
S10	Recognize emergency situations and report and/or notify appropriate personnel.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
S11	Follow personal emergency evacuation procedures.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
S12	Recognize emergency situations and report and/or notify appropriate personnel.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
S13	Learn when equipment requires repair or replacement.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
HEALTH							
H10	Recognize signs and symptoms of common medical conditions.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
H11	Recognize signs and symptoms of common mental health conditions.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
H12	Recognize signs and symptoms of common behavioral health conditions.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				
H13	Recognize signs and symptoms of common behavioral health conditions.	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR	Identify what is an emergency Know how to call for help Know where to go in an emergency Know how to use fire extinguisher Know how to use first aid kit Know how to use AED Know how to use CPR				

The core competencies detail what items are trained by the BVS2, Site Manager and BVS1. Though most of the core competency training is self-explanatory (e.g. FA/BSP training, fatal four protocols, operating work environment equipment), the BVS2 will train the following core competencies:

S-7 Use safe handling and storage techniques for chemicals and cleaners:

a) How to read product labels/MSDS: Most items in the homes do not have the need for MSDS sheets as items are common household products purchased in a local store. MSDS sheets are obtained for items purchased through a distributor, such as "Coastwide Distributors"

b) Safe handling and storage techniques for chemicals and cleaners: The handling information will come from reviewing the product labels. This may only need to be covered for very toxic items (i.e. floor strippers, bleach). As far as the safe storage, this is going to be where you store items (in locked areas) and that all items must remain in their original packages. If they are removed they need to be clearly labeled. In addition, you should remind staff to keep chemicals away from food and clean utensils. If chemicals must be stored in the same room, be sure they are stored in their own area. The area should be below food and utensils so there is no chance of chemicals splashing onto the food and utensils.

H-3: Lifting/positioning:

There are several individuals (primarily in the SOCP medical homes) that utilize a variety of lifting and positioning techniques to assist with mobility, as well as, maintain their physical health. As applies, an equipment-specific training will need to be trained to all new/transfer employees. Any client-specific training will also be provided. **(See Appendix for the equipment-specific training.)**

Earthquake drill Completed every Spring, usually by the 2nd week of April

Fire extinguisher use Completed by at the same time as the Earthquake Drill
<http://www.dhs.state.or.us/spd/tools/dd/socp/fire-exting.pdf>

Emergency/911 Guidelines Starting January 2011, Site Managers will train these guidelines on an annual basis.
http://www.dhs.state.or.us/spd/tools/dd/socp/policy/guidelines/emrg_srvcs.pdf

Incident reporting (in conjunction with the Site Manager)

House specific training: This includes but is not limited to: physical management, nutritional management and behavior management. Specifically, this includes the Outing and daily log.

In-home OIS reviews: These are to be scheduled and completed monthly. The OIS “assistants” (HTT2’s, MTT’s) may be scheduled to train these, however it is the ultimate responsibility of the Behavior Specialist to ensure that these are completed. That is, if the OIS assistant is unable to train all staff, the Behavior Specialist will need to complete the training. **Note:** Follow the OIS Oversight training guidelines. Starting January 2010, 3 TDS1 (WOC) have been providing this training.

Individual ISP’s/BSP’s, all other protocols (except nursing care plans): This needs to be completed each time there is a change to these documents and prior to implementation.

New client transfers, in conjunction with the BVS1, Site Manager and Nursing, as applicable.

In-House medication training follow-up This needs to be completed when:

- a) A new employee has completed the Medication Class (with Central Training), and they have the status of HTT2.
- b) If a new employee has completed the Medication Class and they have the status of HTT1, then the in-house medication follow-up will need to be completed once they have reached the status of HTT2 (typically 6 months after initial hire).
- c) After an employee completes the Central Office 2-year medication re-certification class.
- d) When an employee has transferred to a new home.

Note: *The in-house medication follow-up needs to be completed within 15 days of course completion. The employee cannot pass medications unless they have successfully passed this training.*

DHS: Seniors and People with Disabilities
State Operated Community Program

In-House Follow-up

Administration observations and review of the Transcription Knowledge is to be completed by the Site Manager/BSS or Home Trainer identifying any further supports needed to either the knowledge or actual administration of medication.

Y	N	Observed Skill
		Washed hands
		Materials ready to go (water, cups, etc.) as needed
		Assures attention on administration only (not distracted)
		Compared MAR/TAR (triple check)
		Before administration
		When medication given
		When medication put away & documenting
		Assured 5 Rights followed:
		1. Person
		2. Medication
		3. Dose (numbers, decimals, units correct)
		4. Time (within correct time frame)
		5. Route (oral, eyes, ears, rectal, etc.)
		Assured medication was swallowed, etc.
		Immediately initialed square on MAR/TAR
		Assured signature was on the bottom of the MAR/TAR
		Set up and administered medication to only one individual at a time

Supports identified and plan for providing supports (initial components when completed):

Site Manager/BSS/Trainer _____ Date _____ Staff Signature _____ Date _____

Follow-Up: Staff demonstrates they are no longer in need of any additional support.

Site Manager Signature _____ Date _____ Staff Signature _____ Date _____

Staff Name: _____ Instructions on back

Green - Page 1 of 2 Independent. Healthy. Safe.

Training documentation

Overview: An instruction record will be utilized to document each training. When completing the instruction record remember to record the date that the training was initiated, as well as the duration of the training.

The OIS Oversight Training record will be utilized to document the monthly OIS reviews. This form allows for individuals to be trained on 1 or more techniques throughout the month in incidents where an employee is unable to complete all of the techniques in one single training session. **Starting January 1st, 2010**, the TDS1 (WOC) employees will maintain the OIS Oversight training records.

Instruction Records

The BVS2 will ensure that they complete an **DHS 4562 Employee Instruction Record** for all applicable training provided to staff (with the exception of NEO or Transfer Core Competency training). The following items must be recorded on the instruction record:

Date training started: The date that you began training staff. This should correspond to the earliest date that an employee signs off that they received the training.

Trainer signature(s): Signatures of the trainer(s).

Length of time: Total length of time that the training took. **Remember:** The duration of the training should be structured according to the magnitude of the points covered. For example, at a minimum, training for an ISP and support documents should last an hour.

DHS 4562 Employee Instruction Record
http://dhsresources.hr.state.or.us/WORD_DOCS/DE4562.doc

Directions for completing DHS 4562D Employee Instruction Record
See Appendix

SECTION A: Input and/or check the following in:

- a) **Client(s):** Initial of the client(s) to whom the training pertains.
 - b) **Initial Training:** Check this box if this is the first time that the staff is receiving the training. This would include such training as: A client’s new ISP, client transfers, new and/or changes to policy/procedures, new/revised support documents, etc.
 - c) **Revisions/updates:** Check this box if you are training staff on any updated documents/policies/procedures, etc.
 - d) **Re-training:** Check this box if this is a re-training for any of the staff on the particular subject.
 - e) **Annual training:** Check this box if the training covers any mandatory annual training (e.g. Mandatory Abuse, Dress Code, Fire Extinguisher, Earthquake Drills, etc.).
- Note:** This does not include the mandatory training taught by the Central Training Department (e.g. CPR/First Aid, Conflict Resolution, etc.).
- f) **Internal client transfers:** Check this document if you are training staff when a client transfers to another SOCP home.

SECTION B: This section includes several check boxes to indicate what support/other documents were trained. You must check the appropriate box, and if applicable the date of the document being trained. Check only the applicable boxes; if all were trained then check all.

Points covered: What is included in this section may vary, however the following must be documented (**Note: “See Attached” is not an acceptable entry**):

- a) **ISP Training/internal client transfers/client entries:** If you are training a client’s new ISP/Transfer/Entry, you will check the appropriate boxes in Section B that you are responsible for training. In the **Points covered**, you will indicate “all points in the above marked documents.” If any of the boxes that you marked in **Section B** require that you “list below,” you will individually list these in the points covered, including dates, if applicable. For example, “Constipation Protocol, dated 5/1/10; Insulin Pump, Client Schedule, etc.

- b) **Revisions/updates:** Indicate what the specific revision(s)/update(s) to a particular document are being trained. For example, if client JS' staffing expectations were revised from 15 minute checks while sleeping to 30 minute checks on 5/3/10, you would mark and input the following:
- **Section A:** Client initials (JS), Check "Revisions/updates"
 - **Section B:** Check Staffing Expectations and input the date of 5/3/10
 - **Points covered:** Staff is now to perform 30 minute checks on JS while he is sleeping (or something similar).
- c) **Re-training:** Indicate what was re-trained. If it was the entire contents of a particular document, you will write: "all points in the above marked document." If it was only a part of any document/box marked in section B, indicate the specifics. For example: "JS liquid consumption guidelines: Staff are to....." **Annual Training:** Indicate what documents/training was provided. For example, "Earthquake Drills, Code of Conduct, Mandatory abuse, etc."
- d) **Other:** Indicate the document and if applicable, specific points covered, as well as the document dates (if applicable).

Signatures: In this section, ensure that it is accurately and fully completed. You must include the date that the staff was trained, their name, signature/title, and the trainer's initials.

Record Keeping

Each home will have the following system in place to keep track of staff training needs:

A notebook set up by calendar year that contains all materials trained by month and the original signature sheets for the individual training.

- If the training topic is specific to the individual client and the document is kept in medical /program books, a reference to the document can be made in the notebook and the actual document (e.g. ISP, BSP or other archived documents) kept in the medical /program book if desired. If the document would be discarded when an update is put into place (e.g. protocol or schedule), a copy of the document trained must be in the curriculum book and cross-referenced with the signature of the employee.
- If you are training from a program standard curriculum notebook (e.g. Medical Curriculum, OIS, CPR/1st Aide, etc.) the curriculum can be kept in a clearly marked notebook separate from this one. Be sure that the "copyright" date of the curriculum is clearly indicated on the staff signature sheet (e.g. OIS Manual, Medical Administration Curriculum, etc.). It will be clear exactly what you taught and what updates were included in the training session.

Yearly Cumulative Training Record (Excel spreadsheet)

See Appendix for instructions on how to complete.

A notebook or folder set up by employee name or computer file that contains the **Yearly Cumulative Training Record (excel file)** for each person

These documents must be readily available to the Behavior Specialist, and Site Manager. They will be updated quarterly, at a minimum, to assure they are current. These will be emailed / mailed to the QA Manager on a quarterly basis:

- 4/30 for training performed from January-March,
- 7/31 for training performed from April-June,
- 10/31 for training performed from July-September; and
- 1/31 for training performed from October to December.

Note: *The yearly cumulative training record requires the staff's signature. These signatures only need to be obtained at the end of the year (i.e. when they are sent in by 1/31).*

Include on the **Yearly Cumulative Training Record**, Code of Conduct, 1st Aid/CPR, OIS and Universal Precautions training information. If these are not documented, you cannot purge the certificates at the time of replacement with the current one.

The BVS2 is not responsible for maintaining training records or Yearly Cumulative Training Records for any training that is the responsibility of the Vocational Specialist or Nursing.

Note: *If a staff transfers to a new home within SOCP, it will be the responsibility of the sending BVS2 to email the up-to-date Yearly Cumulative Training Record to the receiving BVS2 within 2 weeks of the transfer.*



Make every effort to schedule your trainings according to the following:

1. When the majority (or most) staff are scheduled to work
2. Shift change can be an optimal time to train
3. Times when the individuals are asleep, having down time in their rooms, etc, are also optimal times to train
4. Combine training opportunities: For example, if you are going to train an OIS review, couple this with another training about changes to DHS/SOCP policies, etc.
5. Coordinate training: For example, if you have an ISP on the 13th of the month, it will need to be trained by the end of the month. You could schedule your OIS reviews

towards the latter part of the month, coordinating them to be during days/times that you had anticipated training the ISP.

Summary: There are specific trainings that are “controllable.” These include ISP training, changes to the BSP as a result of monthly reviews, OIS reviews and some others (e.g. Earthquake Training). By scheduling these trainings ahead of time, you will alleviate much of the stress caused by having to train the more “incidental” material (e.g. new employees, changes to DHS/SOCP policy/procedures, changes to house specifics).

Keep in mind, most people remember: 20% of what they see, 40% of what they see and hear, and 70% of what they hear, see and do.

It is virtually impossible to achieve long-term, verifiable performance improvement or effectiveness with a single training program. New skills take time to become part of a person’s repertoire. As such, it will usually be necessary to perform some type of follow-up with the trainees (**e.g. through existing processes: direct observation, interviews, Incident Report(s) and DHS 4596 Progress Note entries**).

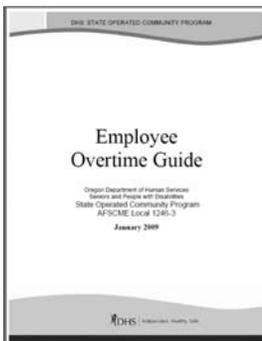
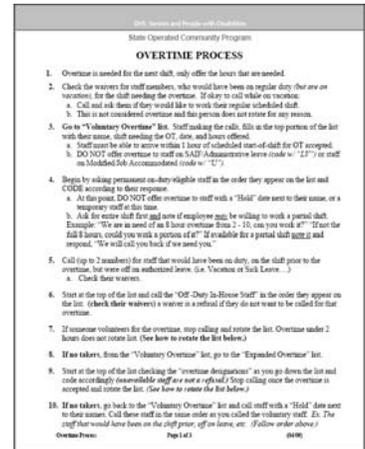
Expanded overtime training

<http://www.dhs.state.or.us/spd/tools/dd/socp/socp-ot-manual.pdf>

Overview: The Expanded Overtime list contains employees names from other homes who would like to work volunteer overtimes at different homes. Employees on this list must be able to arrive at the home needing the overtime within one hour of the scheduled start-of-shift where the overtime was accepted.

BVS2: Employees are responsible for submitting requests to other homes if they are interested in working the overtime in those homes.

- The sign-up period for expanded overtime is June and December of each year.
- Prior to working in a home, other than an employee's primary assignment, staff must attend training before working overtime in the alternate home. The primary Site Manager will provide (if possible) on-duty time for the employee to attend the training.
- Within 2 weeks of the closure of the sign-up period (end of June, end of December) the Behavior Specialist will publish training dates and times (to be done in July and January).
 - These dates and times will occur on all shifts on different days of the week (**at least 3 different shifts**).
 - Training must be completed by July 31st from the June sign-up period and January 31st for the December sign-up period.
- The training will include the following:
 - Basic home layout, location of safety equipment, fire evacuations, etc.
 - Overview of critical information (as identified by the ISP team/Manager) regarding each individual in the home that the employee will be working with. This would include basic communication and interaction techniques, critical safety issues, critical medical issues, critical behavior issues and level of physical intervention that are identified for each individual.



Employee Overtime Guide on the SOCP website training page



4654 Expanded Volunteer Overtime Designation



4658 Volunteer & Expanded Overtime Rotation List



4659 Volunteer Waiver form

Internal client moves

Overview: When moving a client internally, the program wants the move to be a positive one for both the client and staff. Further, to provide staff adequate training to meet the needs of the client.

Program administrators need to have two (2) weeks notice of the transfer, in order to provide time for the mandatory activities/processes.

A “**DHS 4632 Needs Meeting**” will be scheduled by the appropriate designee that includes both sending and receiving Individual Support Plan (ISP) teams (include outreach nurse, if applicable). During this meeting, discussion is centered on the medical and behavioral needs of the client.

Unless the team determines it would have a negative impact on the client:

Staff from the receiving home will visit the client and observe staff’s interactions with them at their current home, prior to the transfer. The client will visit the new home at a minimum of 2-3 times.

Staff from the sending home will be sent to the receiving home to assist with the transition, a minimum of 2-3 shifts following the transfer.

In consideration of the clients, the program believes it would be best not to have peers (clients) move each other’s personal items, unless a property tracking procedure has been established.

If possible, clients should not be moved Friday – Sunday.

BVS2: The Behavioral Specialist for the receiving ISP team should develop a written profile on the individual including: family, aggressions, behavior history current and past, and any medical current and past (this can be the blended plan and/or any other pertinent behavioral support documents).

Note: *If at all possible, the sending BVS2 will provide electronic or paper copies of the individual’s Blended Plan (or FA and BSP), RTR, most recent monthly, 2 year behavior data and master data sheets to the receiving BVS2 prior to the needs/relocation meeting(s).*

BVS2/SM: Prior to the move and after the needs meeting, staff will be trained on all three (3) shifts. This will occur as follows:

1. The receiving Site Manager will coordinate a mandatory training for all staff to attend.
2. This mandatory training will be coordinated with the sending and receiving BVS2 to ensure that they are both available to train and be trained.
 - a). If the individual has a nurse client relationship the outreach nurse will also attend these trainings.
3. The Mandatory training will be scheduled, at a minimum, 10 days after the Needs meeting has occurred.

4. The majority of staff on all shifts will need to be trained prior the client moving in to the new home.
5. If, after the mandatory training, there are a few (not the majority) of staff that have not received training, the receiving Behavioral Specialist will provide this training to them, prior to the staff working with the individual.



Bring your calendar to the needs meeting to ensure that you are able to coordinate trainings with the receiving Behavioral/Vocational Specialist/Site Manger.

If staff believe they have not received adequate training, staff can and should request additional training. Management will review what is needed and provide the necessary tools or training to staff.

Summary: During the needs/relocation meeting(s) the receiving Sending Behavioral Specialist needs to ensure that the individual's behavioral supports are clearly identified and discussed. The Receiving Behavioral Specialists needs to be prepared to ask questions concerning existing supports that may or may not be present at the anticipated home. For example, if an individual is moving from a locked facility into an unlocked facility, the Behavioral Specialist(s) should make mention of this and work with the ISP team to determine if new supports will need to be installed/removed from the receiving home (e.g. installing door/window alarms).

Outside referrals

Overview: Many of the individuals that SOCP supports come from outside providers (e.g. foster care, private residential services, the State Hospital, and at times, from jail). Typically this will occur with some notice, though this is not always the case. In either instance, the individual will come with a referral packet. This packet typically contains such support documents as: FA/BSP, psychological evaluations, and incidents reports. Depending on the individual, these referral packets can be quite extensive or, on the other hand, minimal. As with internal client transfers, needs and entry meetings will be scheduled. In most cases, these meetings are scheduled in advance to provide time for staff training. However, with emergency entries, these can and do occur on the same day that the individual moves into SOCP.

BVS2: The Behavioral Specialist is responsible for developing an “**Entry BSP**” for the referred individual. This entry plan must be developed and trained to staff **prior to the** individual moving into SOCP (or within 24 hours). Though the individual is new to SOCP, and often little may be understood about their behaviors/reactions to the new environment, the BVS2 will proceed with the following to ensure that an adequate entry plan is developed: **(See the Appendix for a Blank Female and Male Entry BSP)**

1. Review the referral packet:

- a. Take a blank copy of the **Entry BSP** and look for information in the referral packet to help fill in the “blanks (i.e. diagnosis, Behaviors to Decrease, Reactive/Proactive Strategies).”

2. Fill in the Blanks:

- a. Contact the sending provider (if applicable) to help fill in any of the missing information, OR, bring up the missing information to the team at the needs/entry meeting.

3. Complete the Entry BSP

- a. Once you have the information that you need to fill in the blanks of the entry plan, you can use the entry BSP template to efficiently complete the document.
 - There are two Entry BSP templates: One for male clients and the other for female clients. Choose the applicable gender.
 - Once open, press the “Ctrl” and “F” keys.
 - This will bring up the box titled “Find and Replace” on the computer screen.
 - Click on the tab, “Replace.”
 - Click on the lower-left-hand tab, “More”
 - Check the box that says “Find whole words only”
 - In the line that says “Find what,” type the word “Client”
 - In the line that says, “Replace with,” type the first name of the referred client (e.g. “Joe.”)
 - Click the tab that says “Replace All”
- b. This function will automatically populate the template with the referred client’s name.
- c. Delete/Add any individual specifics that apply to the referred client (e.g. delete “Unsafe with Flammables,” if the individual does not present with this behavior).

Note: The entry BSP template comes with 2 automatic “Behaviors to Increase: Problem Solving and Relaxation Techniques.” Though the BVS2 may choose to replace these, it is OK in the interim to leave these; however, the BVS2 must review them to ensure that they apply to the referred individual.

- d. The date of the entry BSP will be the date that the individual moved into SOCP.
- e. The line for “Individuals Interviewed/consulted for the Assessment Plan may include the following: Sending providers, Case Managers, or documents from the Referral Packet. When referencing the documents from the packet, be sure to include their title and date (i.e. Oregon State Hospital Sex Offender Risk Assessment 9/17/07).

Summary: The Entry BSP is an “interim support” document. As such, it is not intended to be a substitute for more developed and individualized plans. After an individual moves into SOCP they will have a 60-day ISP (scheduled around 60 days from their entry date). This ISP will proceed like any other annual ISP meeting. Prior to the 60-day ISP, the BVS2 should be very diligent in getting to know and understand the individual (through observation, client/staff interviews, etc.). By doing so, the BVS2 will be able to glean more information for developing a BSP that more specifically addresses the types of supports that an individual may need. The revised BSP for the 60-day ISP will continue to need to be turned into the ISP team 7 days prior to the ISP date.

Legal matters

Overview: Some of the individuals supported by SOCP commit (or have committed) crimes. Our clients don’t do well in jail, prison or Mental Health facilities, nor do they know much about the workings of the legal system. It’s up to us to communicate with everyone throughout the process to sort through the confusion. It’s also up to us to understand the legal systems and support our clients throughout the process.

To begin this understanding, the following is a list of terminology that you may run into if an individual that you support has committed a crime:\

Fitness to Proceed – Determining “Legal Competence” to aid and assist in their own defense

Chapter 161 under the Oregon Revised Statute has a provision for determining if an individual is fit to stand trial as a result of a mental disease or defect. That is to say that they are able to aid & assist in their defense.

- **Do not assume that just because someone presents as “high-functioning” that it will be determined that they are able to aid and assist.**

Before or during the trial in any criminal case, if the court has a reason to doubt the defendant’s fitness to proceed by reason of incapacity, the court may order an examination.

- This examination is usually, but not always conducted at the Oregon State Hospital.

After the evaluation, depending on the results, the following will take place:

- If the evaluation determines that the individual **does have capacity**, the individual will go to court and face charges.
- If the evaluation determines that the individual **won't ever have capacity** ("Never Able to Aid and Assist") then:
 - All charges dismissed,
 - Discharged/released
 - Civil commitment
 - ORS 427 or 426

If the evaluation determines that the individual is **Likely to regain capacity**, then they will stay at OSH to perhaps undergo further training, which could take weeks, months, and sometimes years.

Probation-- Probation is a court-imposed sanction that "releases a convicted offender into the community under a conditional suspended sentence." This practice assumes that most offenders are not dangerous and will respond well to treatment. In fact, the average probationer is a first time and/or non-violent offender who, it is believed, will be best served by remaining in the community while serving out the sentence. While sentences of probation vary widely across and within jurisdictions, the maximum length of time that one can be under supervision is 5 years (60 months)

Intensive Supervised Probation (ISP)

ISP is a form of release into the community that emphasizes close monitoring of convicted offenders and imposes rigorous conditions on that release, such as the following:

- Multiple weekly contacts w/officer
- Random and unannounced drug testing
- Stringent enforcement of conditions, i.e.,: maintaining employment
- Required participation in treatment, education programs, etc.

Since probation is a conditional release, it can be revoked, or taken away, if the conditions governing release are not met (technical violation) or if a new crime is committed during the probationary period (new offense). Probation revocation is initiated by the probation officer's belief that a violation warranting revocation has occurred

If a revocation hearing is scheduled, probationers have the right to testify in their own behalf, may present witnesses, and may have an attorney present

Possible outcomes include return to supervision, reprimand with restoration to supervision, or revocation with imprisonment

Parole-- Parole is the "conditional early release from prison or jail, under supervision, after a portion of the sentence has been served." It assumes that the offender successfully demonstrated conformity to the rules and regulations of the prison environment and shows an ability to conform to society's norms and laws. The fact

that parole involves some incarceration suggests that the average parolee has committed a more serious crime than the average probationer and, hence, poses a greater risk to the community. Therefore, primary goals of parole must include crime deterrence and offender control.

It is similar to probation; however, it differs in that probation is governed by judicial decisions whereas parole is governed by administrative procedures. Most minor infractions are dealt with by the parole officer and may not necessitate involvement of the parole board.

Parolees are usually discharged from prison into the community

Discharged with conditions of release which stipulate specific behaviors that are expected (treatment, UA's, Restitution). Conditions of Release also stipulate what not to do (No contact with victim, no alcohol, no minors)

GEI – Guilty Except for Insanity -- Due to Mental Disease or Defect

A defendant may be found incapacitated if, as a result of mental disease or defect, the defendant is unable:

- To understand the nature of the proceedings against the defendant; or
- To assist and cooperate with the counsel of the defendant; or
- To participate in the defense of the defendant

If an individual is found to be GEI, then **they may** be placed under PSRB.

PSRB – Psychiatric Security Review Board

PSRB acts like a parole board, where they develop conditions that the client must follow or face re-hospitalization and/or face new charges.

A client will remain under PSRB until they are released from PSRB supervision, or

The maximum sentence ends

- Some persons under PSRB jurisdiction stay in the hospital longer than they would have stayed in prison if they had been found guilty through the trial or plea bargain process.

Civil Commitment (426/427) – Court commitment to DHS/SPD for care and custody

Chapter 426 is a provision under the Oregon Revised Statute to civilly commit an individual due to mental disease or defect. This chapter is for committing individuals who are determined Mentally Ill. The term of this commitment can be up to 180 days. The individual is generally committed to a governmental agency such as Dept. of Human Services. The main purpose for pursuing this civil commitment is to gain legal authority over a client who may need to receive treatment against their will.

Chapter 427 is a provision under the Oregon Revised Statute to civilly commit an individual due to mental disease or defect. This chapter is for committing individuals who are determined Mentally Retarded. The term of this commitment can be up to 365 days. The individual is generally committed to a governmental agency such as Dept. of

Human Services. The main purpose for pursuing this civil commitment is to gain legal authority to have the police return the client to the SOCP group home against their will (in the case of Leaves Supervised Settings).

Steps for obtaining a 427:

- Must be MR – not DD only
- Any two people can petition
- Court orders investigation
- 30 days to complete investigation
- Person must be:
 - a) dangerous to self or others, or
 - b) is unable to provide for their personal needs, and
 - c) is not receiving care as is necessary for their health, safety or habilitation
- Diagnostic evaluation conducted
- MR diagnosis confirmed by DHS/SPD D and E coordinator
- Client will be served a citation for hearing
- Commitment hearing scheduled
- Attorney appointed
- District Attorney Representation (not always)
- Hearing convened
- Committed to DHS/SPD (SOCP)
- Committed for one year

Procedure for Renewal of Civil Commitments under Chapter 427

1) By the 7th month (5 months prior to expiration) of the 427 court order, the ISP team including the county Services Coordinator develops a Discussion Record & Change Form with signatures regarding the agreement to continue civil commitment under ORS 427. The Site Manager will forward a copy to The Placement Services Manager if the teams agrees civil commitment is needed**.

Discussion Record example, The Issue could be stated as follows: Client 427 Civil commitment

The Discussion could be stated as follows: Client has exhibited extreme behavior in the community resulting in frequent police involvement. At this time the client is their own guardian and has the right to refuse to return to homes within SOCP. Client will often engage in assaultive behavior towards staff members, community members and law enforcement officers and then has refused to return to the group home, which has resulted in protracted events. This places the client at risk of further involvement with law enforcement with the potential for detainment, where the client may not receive appropriate psychiatric services. At no time is the client safe in the community while unsupervised and for their own safety it would be appropriate to pursue a 427 commitment to ensure that SOCP can maintain supervision of the client.

Decision: This then would be the decision that the team decided (e.g. to pursue the commitment or not).

- 2) The Placement Services Manager will contact the SOCP homes' CDDP Services Coordinator to complete the DMAP 729 Form (funding for administrative exam).
- 3) The Placement Services Manager will contact the SOCP Site Manager requesting an electronic copy (current) of the following documents:
 - FA/BSP
 - PFW
 - Monthly Summary
 - PVO (via Fax)
- 4) The Placement Services Manager will Fax a completed Release of Information to the Site Manager for a client signature/date, and staff witness signature/date. The Site Manager will then Fax it back to The Placement Services Manager and retain the original on site.
- 5) The Placement Services Manager will negotiate an appointment with the psychologist to conduct the client evaluation and advise the Site Manager of same.
- 6) Once the evaluation is complete, the Clinical Services Manager will review and determine whether the results support going forward with a petition. If it does, the Placement Services Manager will coordinate the signing & notarization of the Petition for a civil commitment.
- 7) The placement Services Manager will then submit the petition to the designated CDDP investigator to begin the investigation process. This process will include an interview (either in person or by phone) of the petitioners and the individual. A court date will follow.
**The ISP team should not feel obligated to request a renew of a civil commitment if the risk has changed over the past year. The team should fully re-assess the presence or absence of risk each year.

Mental Health Court

Mental Health Court is designed to divert mentally ill individuals from serving a sentence in jail. As such, the client must be determined mentally ill by the court (AXIS I DX).

- Documentation of past psychological evaluations, **DHS 4576 PVO's** can be invaluable in helping to make this determination.

Once accepted, a client is required to attend "Mental Health Court" on a schedule determined by the court (weekly/monthly).

The sentence is 18 months after which all charges are expunged from the clients criminal history.

A client can be terminated from Mental Health Court should they continue to receive charges during their 18 month tenure.

The client's court appointed attorney is responsible to advocate to the presiding judge for consideration of Mental Health Court. This needs to be done at the initial arraignment.

Guardianship: Chapter 125 under the Oregon Revised Statute provides for appointment of a guardian to promote and protect the well-being of the protected person.

- An adult protected person for whom a guardian has been appointed is NOT presumed to be incompetent.
- A protected person retains all legal and civil rights provided by law except those that have been expressly limited by court order.

General powers and duties of guardian

- Guardian shall provide for the care, comfort and maintenance of the protected person.
- Guardian may consent, refuse consent or withhold or withdraw consent to health care.
- Guardian may make advance funeral & burial arrangements.
- Guardian may make an anatomical gift of all or any part of the body of the protected person.
- Guardian of a minor has the powers and responsibilities of a parent who has legal custody of a child.
- Guardian may receive money and personal property deliverable to a protected person.
- Guardian may consent to the withholding or withdrawing of artificially administered nutrition and hydration for the protected person.

Limitations on guardianship

- Guardian may not use funds from the protected person's estate for room and board that the guardian or relative have furnished for the person.
- Before placing a protected person in a mental health treatment facility, a nursing home or other residential facility, the guardian must file a notice with the court.

BVS2:

1. If you are scheduled to testify (as in the case of civil commitment), bring a 2-yr behavior data summary, a review of significant **DHS 4595 Incident Reports (IR's)**, **DHS 4588 FA/BSP**, list of current RX, psychosocial history.
2. Bring a blank sheet of paper to write down applicable information given during the hearing such as the next hearing date, attorney's name, judge's name, etc.
3. It is also important to arrive at the hearing early. Often an individual's attorney is assigned on a rotating basis, and does not always know them. Arriving early will provide an opportunity for the client and attorney to meet, as well as debrief.

You will gain respect by dressing in a professional manner (no hats, no gum chewing, no ringing phone). Always address the judge as "Your Honor". Leave the "bling" at home, most courts require that you go through security at the front door. **DO NOT** bring your pocket knife or key chain pepper-spray canister as you will be sent away or they will be confiscated **by security**.

Where to find forms and tools

Oregon Technical Assistance Corporation (OTAC):

www.otac.org

DHS Forms Server:

http://dhsforms.hr.state.or.us/forms/databases/FMPRO?-db=FormTbl.fp5&-lay=Main&-format=Findforms_FMP.htm&-findany

State Operated Community Program (SOCP) webpage:

<http://www.dhs.state.or.us/spd/tools/dd/socp/>

Oregon Administrative Rules (OAR) 411-325 (Table of Contents)

24-Hour Residential Services for Children and Adults with Developmental Disabilities:

http://www.sos.state.or.us/archives/rules/OARS_400/OAR_411/411_tofc.html

<http://arcweb.sos.state.or.us/banners/rules.htm>

Oregon Administrative Rules (OAR) 411-345 (Table of Contents)

Employment/Alternative to Employment Services for Individuals with Developmental Disabilities

http://www.sos.state.or.us/archives/rules/OARS_400/OAR_411/411_tofc.html#340

Oregon Revised Statues (ORS): <http://www.leg.state.or.us/ors/>

OTAC forms	DHS Forms Server	SOCP Webpage Tools*
<ul style="list-style-type: none"> Individual Support Plan (ISP) Personal Focus Worksheet (PFW) The Risk Tracking Record (RTR) Action Plans Change Forms 	<ul style="list-style-type: none"> DHS 4588 FA/BSP Blended Plan DHS 4588 Good Day Plan DHS 4588 Interaction Guidelines DHS 4554 Balancing Test DHS 4576 Physician's Visit/Orders DHS 4573 Medication Administration Record (MAR) DHS 4629 Daily Log DHS 4596 Progress Note DHS 4585 Core Competencies DHS 4586 Client Specific Sheets In-House (Green) / Transfer (Blue) DHS 4562 Employee Instruction Record 4654 Expanded Volunteer Overtime Designation DHS 4658 Volunteer and Expanded Overtime Rotation List DHS 4659 Volunteer Waiver form DHS 4632 Needs Meeting 	<ul style="list-style-type: none"> Functional Behavior Assessment FBA Assessment Interview form Client Observation form Accessing Emergency Services guidelines Program approved Protective PPI's Client Monthly Summary Report In-House Training Duties Fire extinguisher use In-House Training Follow-up sheet Yearly Cumulative Training Record Employee Overtime Manual Two-year Cumulative Training Record <p>*Not all of the above are currently posted. Some postings are in progress.</p>

DHS 4595 Incident Report carbonless pads are available through SOCP Central Office:

- 4595 Part 1
- 4595A Part 2
- 4595B Part 3
- 4595C Part 4
- 4595D Part 5

If you have questions about information contained in this **Behavior Specialist Manual**:

Contact the State Operated Community Program.

SOCP Program Administrator 503 378-5952 ext. 242
SOCP Clinical Service Manager 503 378-5952 ext. 244
SOCP Behavior Support Manger 503 378-5952 ext. 245



Department of Human Services
Seniors and People with Disabilities
State Operated Community Program (SOCP)
(503) 378-5952

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