# Frequently Asked Questions from the OHR Statewide Training Series

## General Questions

1. **Are the training presentations available for viewing?**

   • Yes. All four of the OHR statewide training presentations are available on the DBHDS YouTube channel (Reporting in CHRIS: Abuse, Neglect, & Human Rights Complaints; Restrictions, Behavior Treatment Plans, & Restraints; Investigating Abuse & Neglect: An Overview for Community Providers; and The Human Rights Regulations: A Training for Trainers).

   • You may view the training presentations by following the steps below.

   i. Go to YouTube.

   ii. Under SUBSCRIPTIONS, select Browse channels and search for Virginia

   iii. Select the SUBSCRIBE button.

   iv. Select PLAYLISTS, then select VIEW FULL PLAYLIST from the Office of Human Rights Playlist.

   v. From here, scroll through the list of videos until you find the training video you are looking for

   vi. If you are signed into your YouTube account, you can also save the Office of Human Rights Playlist so that it is always in your navigation menu by looking for and selecting this icon.

2. **Are CEUs available for training presentations viewed via the YouTube channel?**

   • No. CEU certificates are only available to participants attending a live/virtual training presentation. Additionally, CEU certificates are only available by request. Please be sure to listen for instructions on how to request a CEU certificate during the training presentation.

**3. Have there been any updates to the visual representation of the human rights poster?**

• The State Human Rights Committee (SHRC) in collaboration with the Office of Human Rights, has established a subcommittee to increase accessibility by Individuals within our service delivery system to information and resources – included, but not limited to, resources to help Individuals better understand their rights on their own, and revision of the rights poster, specifically concerning translation of rights to other languages. Currently, the poster is available for download on the OHR webpage (www.dbhds.virginia.gov ) in Arabic, Chinese, English, Korean, Spanish, and Vietnamese.

**4. How does a Provider know who their assigned Regional Advocate is?**

• The OHR Regional Map is located on the OHR web page which can be accessed from the main DBHDS website (www.dbhds.virginia.gov).

**5. What is the stance on "dignity of risk" related to the practice of allowing Individuals to take risks and/or make mistakes so that they may learn from their mistakes?**

• Individuals receiving services maintain protection to exercise their legal, civil and human rights (see 12VAC35-115-20). For individuals who maintain legal competency and have not been determined to lack capacity based on an evaluation (see 12VAC35-115-145), this extends to making overall life decisions. These decisions may be deemed "good" or "bad". Everyone should have the opportunity to learn from their life decisions.

• Providers are responsible for ensuring individuals have the information needed to make informed decisions. Providers are also required to maintain a safe and therapeutic service environment for all individuals receiving services and in so doing, may limit an Individual's rights in the context of service delivery, if done in accordance with the regulations or other applicable law (see 12VAC35-115-50, and 12VAC35-115-100).

# Overview of the Human Rights Regulations

**1. What OHR information should be listed on the rights poster?**

- At minimum, the information displayed in the form of a poster should include the name of the assigned Regional Advocate (for the region of the specific service location) and their telephone number. This is different from and in addition to providing notice about rights and human rights processes in writing, see 12VAC35-115-40.

**2. If an interpreter is needed for an Individual, who has the responsibility to provide such services?**

- The Provider delivering the service is responsible. CSBs, state operated facilities and OHR staff have access to documentation translation and interpreter services to facilitate their specific interactions as needed.

**3. Do Individuals have to sign their discharge summary? What if discharge planning is included in the ISP?**

- It is the Provider's responsibility to ensure the Individual has participated in the development of not only their ISP, but their discharge plan too. Evidence of the Individual's participation in their discharge planning must be included in the services record.
- 12VAC35-115-70 (A)(1)(c) stipulates that the "services record shall include the signature…of the Individual's or authorized representative's consent."
- Reasonable efforts should be made to obtain the Individual's and/or authorized representative's signature.

**4. If an Individual has a power of attorney, how does that affect consent?**

- When it is determined that an individual lacks the capacity to consent or authorize disclosure (in accordance with 12VAC35-115-145), the provider "shall" recognize and obtain consent or authorization for those decisions for which an individual lacks capacity according to the hierarchy listed in 12VAC35-115-146(A).
- An attorney-in-fact who is currently empowered to consent or authorize the disclosure under the terms of a durable power of attorney for the individual is included in this list.

**5. Are there specific forms a Provider should use when designating an Authorized Representative (AR)?**

• The OHR does not have specific forms for this purpose. This would be the prerogative of the Provider to identify internal processes. However, 12VAC35-115-146 (D) stipulates that the "provider shall document the recognition or designation of an authorized representative in the individual's services record…"

• Should a Next Friend need to be designated, the Provider will need to present the designation to the LHRC after completing the OHR's Next Friend – Request for LHRC Review form. This form can be found on the OHR webpage (www.dbhds.virginia.gov).

**6. Can a guardian limit an Individual from accessing their own services record?**

• No. As documented in 12VAC35-115-90 (C)(2)(a), only "a physician or clinical psychologist involved in providing services to the individual" may deny or limit an Individual's access to their services record. Certain procedures must also be followed as documented in this same section of the Human Rights Regulations (HRR).

**7. Who has the responsibility to have an Individual's capacity assessed?**

• According to 12VAC35-115-145, "the provider shall obtain an evaluation conducted by or under the supervision of a licensed professional who is not directly involved with the individual to determine whether the individual has capacity to consent or to authorize the disclosure of information."

• "Provider" means any person, entity, or organization offering services that is licensed, funded, or operated by the department See 12VAC35-115-30

**8. If a court order requires an Individual to work in a setting that provides constant supervision and the Individual subsequently expresses a preference or desire to work in an unsupervised professional setting, is the Provider required to accommodate the Individual's request or must the Provider check the status of the court order first?**

• Providers are required to comply with court orders. However, it is the Provider's responsibility to honor an Individual's preferences "to the extent possible" (see 12VAC35-

115-70). Providers should maintain open communication with Individuals and their authorized representatives to understand the Individual's preferences, while also being aware of external requirements and working with the Individual and/or AR to develop and implement an individualized services plan that satisfies both needs. In no instance, though, should a Provider violate a court order.

**9. Can it be considered a violation of human rights if a Provider fails to consistently apply program rules to ALL persons receiving services?**

- Yes. Human rights are enforced systemically; however, they are protected and limited individually. It could be a violation if a Provider has program rules and does not apply the rules in the same way to each Individual [see 12VAC35-115-100(B)(7)].

# Reporting in CHRIS: Abuse, Neglect, & Human Rights Complaints

**1. Who is the "director"?**

- As documented in 12VAC35-115-30 of the Human Rights Regulations (HRR), the director is the chief executive officer of any Provider delivering services. In organizations that also include services not covered by the HRR, the director is the chief executive officer of the services or services licensed, funded, or operated by the department.

**2. Is a call to APS or CPS necessary if the Provider's investigation determines there was no abuse or neglect?**

- The HRR in 12VAC35-115-260 (A)(8) requires Providers' compliance with all state laws concerning the reporting of abuse and neglect.
- Providers, as mandated reporters, should report all allegations of abuse and neglect to the appropriate office at the time of discovery.

**3. What constitutes a medication error?**

- "Medication Error" means a mistake by the Provider in administering medication to an Individual receiving a licensed service and includes when any of the following occur:
  - i. The wrong medication is given to an Individual.
  - ii. The wrong dosage of a medication is given to an Individual.
  - iii. The wrong method is used to give the medication to the Individual.
  - iv. The medication is given to an Individual at the wrong time, or not at all.
- When a Provider discovers a medication error that occurred during the provision of their licensed service(s), and the information known at the time of discovery indicates abuse or neglect, or there is an allegation of abuse or neglect as defined in 12VAC35- 115-30, the Provider should enter an Abuse report into CHRIS and conduct an investigation.
- When the information known at the time of discovery does not involve an allegation or indicate abuse or neglect, as defined in 12VAC35-115-30, the Provider should follow their own policy for internal review to include any protocols for monitoring the Individual and documenting the event.

**4. Are medication documentation errors considered reportable to the OHR?**

• If the documentation error did not result in, or have the potential to result in, a serious injury, and the Individual or AR has not filed a complaint, it does not need to be reported to the OHR.

**5. Examples of what are not reportable to OHR?**

• ALL deaths, ALL falls, ALL medication errors. Only incidents where there is a complaint, or the provider has suspicion that a human rights violation occurred are reportable.

• Abuse/Neglect that does not occur during the provision of the provider's service and the alleged abuser is not an employee, contractor or volunteer of the provider.

**6. If I observe or am informed about a potential human rights violation for another provider, what should I do?**

- Contact the OHR Regional Manager for the area where the DBHDS provider (who is involved in the alleged violation occurred) is located. You do not need to know all the details, but it is helpful to be able to relay the name of the individual(s) involved, any involved staff names or titles, and the date(s) of the alleged rights violation.

**7. When a provider's findings are submitted in CHRIS, is there a specific turnaround time to act on the Corrective Action (terminate staff, for example?), or is it the Advocate's discretion?**

- "Immediately" on the same day a provider is made aware of a complaint alleging abuse/neglect, they are required to take steps to protect individuals from harm, see 12VAC35-115-50(D)(3). Following the conclusion of the investigation and the determination that abuse/neglect occurred; the provider could decide these immediate steps will remain in effect and/or other corrective actions will be implemented. While the provider director has 10 working days from the date the investigation is completed to submit an action plan directly to the individual/AR and to the Advocate via CHRIS [12VAC35-115-175(F)(7) ], the goal of the complaint resolution process is to resolve the complaint at the earliest possible stage [12VAC35-115-150(B)]. The Advocate is responsible to ensure a reasonable timeline for the implementation of all appropriate corrective actions and may begin requesting this information as soon as the provider's finding has been entered into CHRIS.

# Investigating Abuse & Neglect: An Overview for Community Providers

**1. Do we have to investigate an individual's complaint when there is no clear date, time and/or accused?**

- Yes. Any complaint that alleges a violation of the human rights regulations must be reported and investigated per 12VAC35-115-175. During the interview with the individual, and/or the person filing the complaint, you should ask questions to try to further define elements of the complaint that remain unknown. If a specific date or time are not provided, you may be able to narrow it down to a period of time (i.e. day shift, after lunch, last week). When the accused is not identified by name, listen for details about the person that may lead to other people you can interview as part of the investigation (i.e. they wear glasses, they only work weekends, they drive a red car).

**2. Are Providers required to follow the investigatory process outlined in the OHR training?**

- The information presented in the OHR Investigating Abuse & Neglect training is heavily sourced from Labor Relations Alternatives, Inc. (LRA) and is considered best practice procedures. Through their own internal policies and procedures, it is the responsibility of the Provider to ensure their trained investigators have a systematic process to follow.

**3. How do investigators become trained to investigate abuse and neglect?**

- Any person responsible for conducting abuse and neglect investigations may participate in this investigation training offered by the OHR, or attend and participate in any other investigation training offered by another entity. Proof of training must be maintained in the investigator's personnel file.

**4. When should the investigation begin and how long do Providers have to conduct the investigation?**

- Per 12VAC35-115-175, investigations must begin as soon as possible but no later than the next business day following discovery of the event or complaint. Additionally, Providers have 10 working days to complete the investigation. Extensions may be requested through the assigned Advocate. Be mindful that extensions are reviewed and

granted by the assigned Advocate for reasonable purposes and should be requested as soon as it becomes clear that the timeframe may not be met.

5. **The full investigative report is required to be input in the Clinical Record. Is it standard for a Support Coordinator/Case Manager to request the entire report? It seems like proprietary information, and have sent copies of notification letters instead, but wanted to make sure what the Office of Human Rights thinks.**
    - It is reasonable for a CSB to request information contained in the individual's services record, as it pertains to the CSB's role for case coordination. The Human Rights Regulations define "services record" as all written and electronic information that a provider keeps about an individual who receives services. This would include information about human rights complaints that involve the individual. The decision to release, or not release information contained in the individuals' services record should be based on the provider's Policies and consistent with the individual's rights and the provider's duties as outlined in 12VAC35-115-80.

6. **Is permission required before taking pictures of an Individual's injuries? What if the Individual is unable to provide consent?**
    - Permission is not required. However, Providers should make the Individual aware and try to take their preferences into account to the greatest extent possible. Providers that take pictures of Individuals should have a policy that addresses, at a minimum, processes for informing the Individual of these practices, the chain of custody and other procedures used to ensure against unauthorized disclosure and protection of the Individual's privacy. Because any information that a Provider has pertaining to an Individual receiving services or anything that identifies an Individual as someone receiving services is considered protected health information, authorization is required from the Individual or their authorized representative prior to disclosure of the picture(s), unless state law or regulation allows or requires further disclosure without authorization.

7. **An individual appealed my decision and action plan following a complaint investigation. I am going before the LHRC for the Appeal Hearing. What do I need to bring?**

- Your copy of the petition
- Your response with Exhibits
- A copy of the CHRIS report
- Witnesses (as applicable)
- Snacks and drinks are permitted

**8. I am going before the LHRC for an Appeal Hearing - will the hearing recorded?**

- No. The hearing is not recorded by the Office of Human Rights. The LHRC Findings and Recommendations act as the record of the hearing. Either party may choose to record the hearing and if they decide to do so, it is encouraged that they inform the assigned Advocate in addition to the other party.

# Restrictions, Behavioral Treatment Plans, & Restraints

1. **Is a licensed behavior analyst considered a "licensed professional"?**
    - No. Per 12VAC35-115-30 "Licensed professional" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed or certified substance abuse treatment practitioner, or licensed psychiatric nurse practitioner
    - LBA's are authorized to write, revise and oversee restrictive and nonrestrictive behavior plans per specifical authority given to them in 12VAC35-115-105(B).
    - Because LBA's are not identified in the defined list as a "licensed professional", LBA's are not permitted to assess the clinical necessity of restrictions being implemented under 12VAC35-115-50(C), or to perform capacity evaluations under 12VAC35-115-145

2. **Can a licensed eligible clinician assess and determine the need for a restriction under Dignity (12VAC35-115-50)?**

    • Yes. If the licensed-eligible clinician is registered with their respective Board (e.g., Board of Counseling, Virginia Board of Social Work), has a valid and enforceable supervisory contract with a licensed professional (see 12VAC35-115-30) which includes having their work reviewed and signed off on by the licensed professional, the licensed-eligible clinician may assess and determine the need for a restriction under 12VAC35-115-50.

3. **When does a restriction need to be reviewed and/or approved by the LHRC?**

    • Any restriction, both under section 50 or 100, lasting longer than 7 days or being imposed 3 or more times within a 30-day period must be reviewed and approved by the LHRC. The Restrictions to Dignity and Freedoms of Everyday Life Request for LHRC Review form must be completed. Please check with your assigned Regional Advocate for instructions on submission of the form. LHRC Review Forms can be found on the OHR webpage (www.dbhds.virginia.gov)

4. **If a restriction is court ordered, does that restriction have to be reviewed by the LHRC?**

   • No. Court-ordered restrictions do not need LHRC review. Per 12VAC35-115-100 (B)(5), "Providers shall obtain approval of the LHRC of any restriction imposed [emphasis added] on an individual's rights under [emphasis added] this subsection or 12VAC35- 115-50 that lasts longer than seven days or is imposed three or more times during a 30- day-time period."

   • Additionally, per 12VAC35-115-100 (B)(4), restrictions that are imposed by the court are not "imposed under" the human rights regulations. All that is necessary for court ordered restrictions is that they be documented in the Individual's services record, in accordance with 12VAC35-115-100 (B)(4) that reads: "If a court has ordered the provider to impose the restriction or if the provider is otherwise required by law to impose the restriction, the restriction shall be documented in the individual's services record."

5. **How long does it take to get a response or confirmation for LHRC review?**

   • This timeframe is variable; however, decisions made during the LHRC meeting are effective immediately.

   • Providers should confer with their assigned Regional Advocate or Human Rights Advocate to be placed on the agenda for an LHRC review or other LHRC business. The LHRC Meeting Schedule and LHRC Review Forms can be found on the OHR webpage (www.dbhds.virginia.gov).

6. **Can restrictions be imposed prior to LHRC review?**

   • LHRC review of restrictions to an Individuals assured rights under 12VAC35-115-50 and 12VAC35-115-100 may occur AFTER implementation. This may happen as the "three or more times in a 30-day period" and "lasting longer than 7 days" thresholds are met. However, the Advocate must be notified of proposed restrictions to assured rights under Dignity (12VAC35-115-50) and the reasons for the proposed restriction PRIOR to implementation. If LHRC review occurs after a restriction has been implemented; the Provider must ensure the restriction is at all times justified and carried out according to sections 50 and/or 100 of the Human Rights Regulations (HRR).

7. **Can a behavior plan suggest or include Providers wear arm guards for their own protection during instances of physical aggression by an individual; and if so, does this required any type of higher level review (e.g., LHRC).**

   - Yes, a behavioral plan can suggest or include Provider use of arm guards. While not required, it is encouraged to include this in the behavior plan to educate everyone as to how the arm guards are supposed to be used, under what circumstances they are to be used, and by whom; in effort to reduce the likelihood of improper use on or with the individual.
   - Arm guards for a provider staff do not require LHRC review because they do not limit the individual's freedom of movement (restriction), and they are not being applied to the individual's body at all or in a way that prevents them from taking them off or moving their body freely (restraint).

8. **Do the LHRC Review forms have to be redacted (*removal of Personal Health Information/Personal Identifying Information)?**

   • Yes. LHRC Review forms should not contain any PHI/PII. In addition, any information submitted along with the form must have all PHI/PII redacted prior to submission. Please consult your assigned Regional Advocate for questions about what should be redacted, and instructions on the method used to code the forms for tracking purposes.

9. **Prior to taking a BTP with restraint or time-out to the LHRC, it must be reviewed by an Independent Review Committee (IRC). I work for a small company or independently. How do I access an IRC? Can I create an IRC?**

   - Per 12VAC35-115-30. Definitions, "Independent review committee" means a committee appointed or accessed by a provider to review and approve the clinical efficacy of the provider's behavioral treatment plans and associated data collection procedures. An independent review committee shall be composed of professionals with training and experience in behavior analysis and interventions who are not involved in the development of the plan or directly providing services to the individual.
   - It is fine to develop an IRC – but not be part of the review of a plan that you are involved with. IRCs should consist of three (3) or more professionals. *Any restrictive Behavioral Plan must go before an IRC for review of the technical adequacy of the Plan prior to the required LHRC review, and it must continue to be reviewed by the IRC quarterly. See

12VAC35-115-105 Behavioral Treatment Plans, specifically -105(C)(3), -105(E) and -105(G).

- Providers have the option to join resources with other providers. This is a common model in Northern Virginia. Accessing a local Community Services Board or other private providers that are potentially open to reviewing outside plans is additionally acceptable, upon confidentiality procedures being established.

10. **Currently, most BTP's in Therapeutic Consultation have something along the lines of "use program's crisis management strategies" when client is in imminent danger to self or others. Along with contacting REACH or 911, etc. Would these instances of restraint have to go to the IRC then LHRC?**

    - No. A provider is expected to utilize approved crisis management strategies in an emergency, as described in the program's policies and procedures.

11. **To clarify, are you saying that providers can ONLY implement a restraint ONLY after a licensed professional or LBA has conducted a detailed and systematic assessment?**

    - No. Providers can utilize restraint in an emergency consistent with their approved policies. The requirement for ONLY implementing restraint AFTER a licensed professional or LBA has conducted a detailed and systematic assessment is connected to the use of restraint that is written into a Behavioral Treatment Plan.

12. **I am an LBA. The provider I work with is presenting a BTP to the LHRC. How do I know the outcome of the review/meeting?**
    - Providers receive a signed copy of the LHRC Review Form at the conclusion of the LHRC meeting. Professionals should review the document with the provider.
    - Draft minutes from every LHRC meeting are also posted to the OHR webpage within 3 business days after the meeting occurred. LHRC & SHRC - (virginia.gov)

13. **Can a legal guardian override a Provider and implement a restriction?**

    • While a legal guardian has the legal authority to request the Provider to impose a restriction on the Individual served, it is the Provider's duty and responsibility to assess the need for the restriction according to the Individual's health, safety, and welfare; to ensure the restriction, if imposed, does not conflict with the individuals assured rights and if imposed, is done so in accordance with processes required in the HRR. See 12VAC35-115-50 and 12VAC35-115-100

14. **If a parent or guardian restrains their own child or the Individual, they are responsible for, is the restraint reportable to the OHR?**

    • Providers licensed, funded, or operated by DBHDS are subject to the HRR, and therefore, any person who is employed by a DBHDS Provider is subject to the HRR. When a parent or legal guardian is employed by a DBHDS provider (for example as a Sponsor Provider), incidents that qualify as reportable to OHR must be reported to OHR.

    • Providers are required to submit annual data about the use of restraint (and seclusion) to OHR by January 15th for the prior calendar year. Information about what to report, how to report and when to report this data can be found on the OHHR webpage under "Resourced for Licensed Providers" (www.dbhds.virginia.gov). Otherwise, only instances of unauthorized restraint or restraint that resulted in a complaint are reportable in real time to OHR in CHRIS.

15. **Please provide clarification on the use of PRN medications, related to standing orders, in regard to controlling behaviors during an emergency – specifically pharmacological restraints.**

    • Providers are prohibited from issuing standing orders for the use of seclusion or restraint (pharmacological, or otherwise) for behavioral purposes (see 12VAC35-115- 110).

    • Restraint is the last resort and whether it is appropriate in any situation is a matter of professional/clinical judgment. Emergency is defined as a "situation that requires a person to take immediate action to avoid harm, injury, or death to an individual or to others." Pharmacological restraint means "the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition." When use of the PRN is not voluntary, and it is used to address behavior creating imminent risk, it is a pharmacological restraint. Under these circumstances, the Provider must adhere to a doctor's order with instructions and criteria for use and discontinuation of the PRN. If a Provider utilizes pharmacological restraint, they must have a restraint policy to specifically include pharmacological restraint and best practice is to also have a protocol in place specific to the Individual that details when to provide the PRN medication in an emergency.

**15. What is meant by "voluntary" concerning the use of restraints?**

• A restraint is the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an Individual from moving his body to engage in a behavior that places him or others at imminent risk.

• If an Individual needs certain supports to increase their functioning, and the Individual voluntarily chooses to use the support or protective equipment, the use of the support or protective equipment is not considered to be a restraint. This means that the Individual can remove the device when they want. The use of protective equipment used for a protective purpose does not require LHRC review.

**16. Do restraints for medical purposes have to be reviewed by the LHRC?**

• Using a physical hold, medication, or mechanical device to limit mobility of an Individual for medical, diagnostic, or surgical purposes does not require LHRC review. Restraints for Medical Purposes are specific and are related to specific medical procedures. The required protections as outlined in 12VAC35-115-100 (B)(3)(a-e) of the HRR must be documented in the Individual's services record.

**17. Which type of Providers may implement program rules?**

• Any Provider (e.g., residential, inpatient, community-based, state operated facility) may implement program rules. Note providers of services subject to the Home and Community Based Services Settings Rule should consult with DMAS. What is significant to understand about program rules is that they are standards of conduct for all Individuals within the program and may not be in conflict with the HRR. See 12VAC35-115-100(B)(7)

**18. If a provider develops (*or revises) Program Rules, do they need to be shared with the Advocate before implementation?**

• Yes. Per 12VAC35-115-260(A)(9) providers shall submit to the Human Rights Advocate for review and comment proposed policies, procedures, or practices that may affect individual human rights.