CHAPTER 4

ICF/MR (DD)
ICF/DD - Intermediate Care Facility for the Developmentally Disabled (ICF/DD or ICF/MR).

I. DIAGNOSTIC CRITERIA FOR DEVELOPMENTAL DISABILILITY (DSM-IV)
1. Low intelligence < 70 I.Q.
2. At least 2 deficits in the following adaptive functioning:
   communication, self care, home living, social/interpersonal skills, use of community resources,
   self-direction, functional academic skills, work, leisure, health and safety
3. Onset before age 18

II. CLASSIFICATION BASED ON I.Q.
1. MILD – (IQ 55-69) represents 80% of the D.D. (slower to talk, walk and feed themselves)
2. MODERATE – (I.Q. 40 – 54)
3. SEVERE – (IQ 25-39)
4. PROFOUND – (IQ <24)

III. PREVELANCE OF MENTAL RETARDATION
1. 1-3% of the population
2. 7,400 ICF/MR’s in the US
3. 130, 000 patients living in ICF/MR’s
4. 6 million patients living in the community (including group homes)
5. living longer than previously due to advanced treatments. Now 40% survive to age 60

IV. CAUSES OF RETARDATION
1. 25% of cases are due to organic factors
   1) chromosomal disorders ( down’s syndrome)
   2) prenatal infections
   3) endocrine (creatinism)
   4) genetic deficits
   5) toxins (fetal alcohol syndrome)
2. 40% of all patients have no known cause

V. DUAL ILLNESS
1. Dual illness = mental retardation + mental disease
2. Mental illness in this population is 4 to 6 times the general population
3. Dual illness is often missed as part of the diagnosis
4. Interdisciplinary teams have contributed greatly to better diagnosis & treatment

VI. COMMON BEHAVIORAL PROBLEMS
1. Physically aggressive behaviors
2. Explosive Rage
3. Destruction of property
4. self injury
5. sexually inappropriate behavior
6. offensive – arson, stealing & other crimes

VII. LIFE EXPECTANCY
1. In the 1930’s < 19 y/o
2. In the 1970’s < 59 y/o
3. In the 1990’s > 70 y/o
VIII. Key Players in the ICF-DD:
1. Program Director (Administrator)
2. QDDP (Qualified Developmental Disability Professional)
3. Clients - (Residents or Patients)
4. Interdisciplinary Team - All personnel involved in the care of the client (Consumer).
5. Director of Nursing
6. Medical Director
7. Clinical Psychologist
8. Behavior Specialist

IX. LEGAL REQUIREMENTS FOR THE ICF-DD
1. Consultant Pharmacist required
2. The facility must have at least a schedule I institutional permit.
3. Drug regimen review required on each client Q 90 days or more often if necessary and report irregularities to the attending physician and the interdisciplinary team.
4. The consultant must inspect the facility at least monthly and provide a written report.
5. Consultant Pharmacist participates in active treatment plan review and annual habilitation plan development.
6. Policies and procedures manual required – must be updated at least yearly.
7. A contract with a Florida registered pharmacy to provide medications.
8. A contract with a Florida Registered Consultant Pharmacist
9. The term used to describe the developmentally delayed patient has evolved from Patient to Client to Resident to Consumer
10. Annual inspection by ACHA survey team, Florida Dept of Health – Division of Medical Quality Assurance and possibly CARF (Commission on Accreditation of Rehabilitation Facilities.

X. Other Facilities providing services for the Developmentally Disabled Consumers
* 1. Group Home
* 2. ADT (Adult Day Treatment Center)
   a) Workshops
   b) Child Care Programs
3. Specialty Schools

* These facilities are now surveyed by the Florida Agency for Persons with Disabilities (A.P.D.)
WEBSITE RESOURCES ON MENTAL RETARDATION

NATIONAL ASSOCIATION FOR DOWN’S SYNDROME
www.nads.org

NATIONAL DOWN’S SYNDROME SOCIETY
www.ndss.org

AMERICAN ASSOCIATION ON INTELLECTUAL & DEVELOPMENTAL DISABILITIES
www.aamr.org

H.H.S. ADMINISTRATION FOR CHILDREN & FAMILIES
www.acf.dhhs.gov/programs/add/

ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES
www.aucid.org

C.D.C. SITE ON AUTISM
www.cdc.gov/ncbddd/dd/ddautism.htm

NATIONAL ASSOCIATION FOR THE DUALLY DIAGNOSED
www.thenadd.org

PRADER WILLI SYNDROME ASSOCIATION
www.pwsausa.org

REFERENCE BOOKS ON DEVELOPMENTAL DISABILITIES

EPILEPSY AND MENTAL RETARDATION
Author: Sillanpaa, Matti (1999) Publisher: Routledge

GENETICS AND MENTAL RETARDATION SYNDROMES
Author: Dykens, Elisabeth (2000) Publisher: Paul H Brookes

PSYCHIATRIC AND BEHAVIORAL DISORDERS IN DEVELOPMENTAL DISABILITIES
Author: Bouras, Holt (2006) Publisher: Cambridge University Press
§483.460(i) Standard: Pharmacy Services

The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

Guidelines 483.460(i)

Emphasis is placed on the provision of the service, and not on its method of delivery.

Whether the facility utilizes the unit dose, individual prescription or a combination of these systems, or whether the facility has its own pharmacy or provides the service through arrangement with a community pharmacy, the emphasis is on the accuracy of the drug distribution system and the effectiveness of the drug therapy.

§483.460(j) Standard: Drug Regimen Review

A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

Facility Practices 483.460(j)(1)

The IDT provides the pharmacist with relevant input for the drug regimen review (e.g., changes in behavior, new medication the person has begun taking, etc.).

Reviews are performed as often as individual need dictates, but not less than quarterly.
Guidelines  §483.460(j)(1)

The pharmacist should review on a more frequent basis the drug regimen of individuals whose response indicates problems with drug therapy. Refer to the “Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews” as stated in Appendix N to the State Operations Manual (Pharmaceutical Service Requirements in Long Term Care Facilities) to evaluate the drug regimen review done by the pharmacist.

Probes  §483.460(j)(l)

Does this review look at the individual’s response to the drug?

W363

§483.460(j)(2) The pharmacist must report any irregularities in clients’ drug regimens to the prescribing physician and interdisciplinary team.

Facility Practices  §483.460(j)(2)

The pharmacist identifies apparent irregularities and determines their significance.

The pharmacist reports apparent irregularities which are significant to the physician and the IDT.

The physician and IDT are aware of all irregularities in the individual’s drug regimen.

Guidelines  §483.460(j)(2)

The physician and interdisciplinary team must consider the report of the pharmacist and determine whether to accept or reject the recommendations in the report. The pharmacist is not required to repeatedly report the same minor irregularities which have already been considered by the physician and the interdisciplinary team, but were rejected based upon the individual’s specific condition.

Survey Procedure  §483.460(j)(2)

Review the drug regimen reviews of sampled individuals in order to determine if the pharmacist has appropriately reviewed the drug regimen on a quarterly basis. Refer to the “Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews” as stated in Part One of Appendix N (Pharmaceutical Service Requirements in Long Term Care Facilities). Appendix N lists many apparent drug irregularities that can occur.

The following exceptions apply to the “List of Apparent Irregularities” in Section II.E.2 of Appendix N:
1. “Use of a listed antipsychotic drug unless one of the following specific conditions exists...” At the present time we have not developed a list of conditions which limit the use of antipsychotic drugs for individuals in ICFs/MR.

2. “Use of antipsychotic drugs in the absence of gradual dose withdrawal attempted every six months...” In ICFs/MR, the requirement is that gradual reduction be attempted at least annually unless clinically contraindicated. See W316 and W317.

3. “The use of a p.r.n. [as needed] antipsychotic drug more than five times...” Standing or as needed programs to control inappropriate behavior are not permitted under the ICF/MR regulations. A drug may be used in an emergency situation, but emergency drug usage can not continue until that usage has been approved by the interdisciplinary team and included in the active treatment program. See W290, W311 and W312.

W364

§483.460(j)(3) The pharmacist must prepare a record of each client’s drug regimen reviews and the facility must maintain that record.

W365

§483.460(j)(4) An individual medication administration record must be maintained for each client

Guidelines §483.460(j)(4)

Each dose of medication, whether self-administered or not, shall be properly recorded in the individual’s record. The intent of this requirement is to maintain a record of drugs administered.

W366

§483.460(j)(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client’s individual program plan either in person or through written report to the interdisciplinary team.

Guidelines §483.460(j)(5)

This regulation does not exclude the pharmacist from the evaluation process, but the pharmacist can best determine how to expend his/her efforts most productively in service to individuals at the facility.
483.460(k) Standard: Drug Administration W367

The facility must have an organized system for drug administration that identifies each drug up to the point of administration.

The system must assure that

W368

§483.460(k)(1) All drugs are administered in compliance with the physician’s orders;

W369

§483.460(k)(2) All drugs, including those that are self-administered, are administered without error;

Guidelines §483.460(k)(2)

A medication “error” is a discrepancy between what the physician has ordered, and what you observe during the drug pass observation. The regulation does not allow for any medication errors.

“Self administered” means administration of medications by the individual, independent of a staff person obtaining, selecting, and preparing the medications for the individual. This includes all usage forms (oral, injections and suppositories).

The individual should be trained until he/she can perform this function without error.

Survey Procedure §483.460(k)(2)

Use the observation technique to determine medication errors. The observation technique involves observing the administration of drugs, recording what is observed, and reconciling the record of observation with the physician’s orders to determine whether or not medication errors have occurred.

Do not rely on paper review to determine medication errors. Detection of blank spaces on the medication administration record does not constitute the detection of actual medication errors. Paper review only identifies possible errors.
Observation Technique

Follow these steps to detect medication errors:

1. Identify the drug product. Determine what drugs, in what strength and dosage forms, etc., are being administered. There are two principle ways of doing this. In most cases, they are used in combination.
   - Identify the product by its size, shape and color. Many products have a distinctive size, shape or color. However, this technique can be problematic because not all products are distinctive.
   - Identify the product by observing the label. When the punch card or unit dose system is used, you can usually observe the label and adequately identify the drug product. When the vial system is used, observing the label is sometimes difficult. Ask the person administering medications to identify the drug product.

2. Observe the administration of drugs. Record your observations in your notes.
   - Follow the person administering medications and observe the individuals receiving drugs (e.g., actually swallowing oral dosage forms). Be as neutral and as unobtrusive as possible during this process.

Watch 16 drug doses being administered to the individuals residing in the facility, or observe a 100 percent sample of the residents in the facility whichever is smaller. For example, in a four bed facility with each individual taking two morning doses, you would watch a 100 percent sample of the individuals since only eight doses would have been administered. In an eight bed facility with each individual taking four morning doses you would observe a sample of 16 doses being administered.

In a large facility, a larger sample (40 to 50 doses) taken from different units in the facility should be observed to ensure that an adequate sample of the drug distribution system has been evaluated.

It is usually preferable to watch the morning pass because more doses per individual are administered at that time; however, you may observe the pass at any time. Observe more than one staff member administering drugs, if possible. You may observe the drugs being administered in the individual’s living quarters or in the day program if the day program is operated by the ICF/MR on its grounds (i.e., the day program is not a separately certified entity).

If there are individuals at the facility who self-administer medications, attempt to observe the self-administration (see W373). Respect the individual’s right to privacy by verbally asking the individual for permission to observe.
Note every detail about drug administration in your notes. For example, “eye drops administered to both eyes” or “nurse took pulse” or “all drugs crushed and administered in applesauce.”

3. Record, in your notes, the most current physician’s orders for those individuals who were observed receiving medications. The latest recapitulation of drug orders is sufficient for determining whether a valid order exists, provided that the physician has signed the “recap.” The signed “recap” and subsequent orders constitute a legal authorization to administer the drug. You should now have a complete record of what you observed, and what should have occurred according to the physician orders.

4. Reconcile your record of observation with the physician’s orders. Compare your record of observation to the most current signed orders for drugs.

☐ For each drug on your list: Was it administered according to the physician’s orders? For example, in the correct strength, by the correct route? Was there a valid order for the drug?

☐ For drugs not on your list: Are there orders for drugs that should have been administered, but were not? Such circumstances represent omitted doses, which is one of the most frequent types of errors.

5. Determine the number of errors by adding the errors for each individual. Before concluding that an error has occurred, discuss the apparent error with the person who administered the drug. There may be a logical explanation, such as a more recent physician order which you have not seen.

6. Timing errors: If a drug is ordered before meals (AC) and administered after meals (PC) or vice versa, always count this as an error. If the drug is administered more than 60 minutes later or earlier than its scheduled administration time, count this as an error ONLY IF THAT WRONG TIME ERROR CAN CAUSE THE INDIVIDUAL DISCOMFORT OR JEOPARDIZE THE RESIDENT’S HEALTH AND SAFETY. Counting a drug with a long half-life (beyond 24 hours) as a wrong time error when it is 15 minutes late is improper because there is no significant impact on the individual. To determine the scheduled administration time, examine the facility’s policy relative to dosing schedules.
§483.460(k)(3) Unlicensed personnel are allowed to administer drugs only if State law permits;

Guidelines §483.460(k)(3)

“Unlicensed personnel” of the facility does not refer to the situation of individuals administering their own medication. Unlicensed personnel administer only those forms of medication which State law permits.

§483.460(k)(4) Clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise;

Facility Practices §483.460(k)(4)

Based on assessment results and IDT discussion, the individual is instructed in skills leading to self-administration of medication, when appropriate, based on the person’s functional abilities.

No individual is precluded from training based solely on diagnosis or level of functioning.

Probes §483.460(k)(4)

Is there a pattern of refusal to allow self-medication?

How is the health and safety of individuals assured during training for self-medication?

§483.460(k)(5) The client’s physician is informed of the interdisciplinary team’s decision that self-administration of medications is an objective for the client;

§483.460(k)(6) No client self-administers medication until he or she demonstrates the competency to do so;

Facility Practices §483.460(k)(6)

Individuals are supervised during self-administration training programs.

Individuals who demonstrate and master self-administration at the level and frequency specified, administer independent of staff.
Guidelines §483.460(k)(6)

Do not expect individuals served to be more knowledgeable than members of the general public in order to self-administer medication. There is no requirement for the individual to be able to state both the generic and brand names of the medication being taken, nor is it expected that the individual be able to list all potential side effects of the medication. The test of competency to self-administer is whether the individual can take the correct medication, in the correct dosage, at the correct time.

Probes §483.460(k)(6)

Is there a pattern that all individuals self-medicate whether they can demonstrate the skill or not?

W374

§483.460(k)(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law;

Guidelines §483.460(k)(7)

When individuals go out of a facility for home visits, or to attend workshops or school, drugs they are taking must be packaged and labeled in accordance with State law by a responsible person approved to administer medications. Be aware whether or not there are applicable State laws which may allow packaging by someone other than the pharmacist.

The test of adequacy of packaging and labeling is whether or not other persons administering medications are able to identify the individual’s medication, method of administration, contraindications, if appropriate, and administration schedule.

§483.460(k)(8) Drug administration errors and adverse drug reactions are

W375

recorded

W376

and reported immediately to a physician.
§483.460(l) Standard: Drug Storage and Recordkeeping

§483.460(l)(1) The facility must store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

§483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Guidelines §483.460(l)(2) “Authorized persons” must be restricted to those who administer the drugs and nursing supervisors (if any). No other personnel should have access to these keys.

Clients who have been trained to self administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply.
Drugs that are self-administered do not have to be double locked. The purpose for the double locking is to limit access to scheduled drugs. Since the individual is generally the only one who has access to his/her drug supply (with perhaps the exception of a facility’s Director of Nursing Services, who may have access to all of the facility’s drug supplies), there is no need to further limit access.

§483.460(l)(3) The facility must maintain records of the receipt and disposition of all controlled drugs.

The facility may also use the medication administration record for purposes of documenting receipt and disposition of controlled drugs. By recording the amount received, a record of the receipt and disposition, can be realized.


Reconciliation of receipt and disposition of controlled drugs need not be done on each shift. If periodic (e.g., weekly or monthly) reconciliations indicate losses, more frequent reconciliation (daily or by shift) may need to be performed to identify and stop losses.

§483.460(l)(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs
§483.460(m) Standard: Drug Labeling

§483.460(m)(1) Labeling of drugs and biologicals must

§483.460(m)(1)(i) Be based on currently accepted professional principles and practices; and

§483.460(m)(1)(ii) Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

§483.460(m)(2) The facility must remove from use--

§483.460(m)(2)(i) Outdated drugs; and

§483.460(m)(2)(ii) Drug containers with worn, illegible, or missing labels.

§483.460(m)(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client’s current medication supply if discontinued by the physician.

Guidelines §483.460(m)(3)

If a physician discontinues a drug for a particular individual, that particular drug supply should be removed from its usual storage area. This precludes that drug from being administered to the individual in error.
CHAPTER 65G-7 MEDICATION ADMINISTRATION FOR
CLIENTS UNDER “AGENCY FOR PERSONS WITH DISABILITY”
SUMMARY OF REGULATIONS

(Full Chapter 65G-7 available at http://apd.myflorida.com/default.htm)

I. WHO FALLS UNDER THESE REGULATIONS

1. Covers clients living in residential facilities under Chapter 393
2. Other facilities where clients receive training, respite care or other services on a regularly scheduled basis
3. Clients living in the community who are serviced by the Agency for Persons with Disabilities

II. DEFINITIONS OF INTEREST

1. Authorized representatives – client’s parents, clients authorized guardian, court appointed guardian, health care surrogate or health care proxy
2. Enteral medications – seem to only address supplements “delivered via a tube”
3. Medication Assistance Provider – someone authorized to assist in the administration of medication. Does not include people who are licensed to administer (i.e. RN or LPN). Must complete an “agency approved training course” + validation.
4. Supervised self administration – means direct, face to face observation to ensure correct administration
5. Validation – The process of validating that an unlicensed “direct service provider” demonstrates competency after they have completed an approved 4 hour training program. Validation may be done by a R.N. or an ARNP.
   a. must be re-validated every year within 60 days of expiration date
   b. if validation expires must retake the 4 hour course and validation again
6. These regulations do not affect RN’s (or LPN’s), client family members or friends, or providers under contract with an ICF-DD’s

III. THE MEDICATION ADMINISTRATION TRAINING COURSE (65G-7.003)

1. If the course is not offered by ADP it must be approved by the agency in order to provide validation
2. Current course providers will have 180 days after this rule is adopted in order to get approved by the agency. They may continue to train during these 6 months
3. Course must be taught by an RN or ARNP
4. Course can either be live or online (i.e. web based)
5. Course must be a minimum of 4 hours with no more than 20 participants at a time
8. Participant must get a grade of 80 or higher to pass the agency approved exam

IV. VALIDATION REQUIREMENTS

1. Must demonstrate competency at least annually in order to administer medication or supervise the self administration of medication
2. Only an RN or a physician may validate
3. Person must demonstrate a 100% proficiency during validation
4. May only administer dosage forms that they have been trained and validated on.
5. Must have the ability to review drug information on the purpose of the medication, common side effects and adverse effects
V. MEDICATION ADMINISTRATION PROCEDURES

1. Certification and validation only covers oral, transdermal, ophthalmic, otic, rectal, inhaled and topical medications
2. Must observe a client for a minimum of 20 minutes following the first 3 doses of a new or PRN medication for potential side effects
3. May not assist with the administration of any OTC unless there is a written order for the drug by the healthcare practitioner
4. May crush, dilute or mix if there are directions from the prescriber to do so.
5. May not assist with a PRN med (either RX or OTC) unless prescriber has written specific directions for the medication including:
   a. name of the medication
   b. prescription number
   c. the prescribed dosage
   d. specific directions including maximum doses, maximum days and when prescriber should be notified
6. Cannot administer or assist with syringe dosage forms, vaginal medications, enteral administrations or meds given via tracheostomy

VI. MEDICATION ERRORS

1. An error includes:
   a. wrong medication
   b. wrong dose
   c. wrong route
   d. use of a medication for other than the intended use
   e. failure to administer within 2 hour window (1 hour before or after designated administration time)
   f. wrong client
   g. failure to administer an expected medication
   i. failure to document administration on the MAR
   j. failure to order a new order within 24 hours of receipt of prescription
   k. failure to refill a prescription before it runs out
   l. administration of expired medication
   m. failure to conduct an accurate count of controlled medications
2. All medication errors must be documented on a “medication Error Report” which needs to be reported to the administrator + the agency within 24 hours of the error
3. Following a medication count a medication assistance provider must report a discrepancy in the accounting of controlled substances to the area office no later than 5pm the next business day
4. The agency case manager may require additional training to prevent future areas.

VII. STORAGE MEDICATION

1. Medication Destruction Record created – doesn’t discuss how destruction should take place
2. Samples can be used but must be labeled by the prescriber’s office. Staff must document the date the medication is opened
3. Maintain OTC’s in their original container
4. Medications not stored centrally must be kept in a secure locked place within the clients room
5. Centrally stored controlled meds must be stored separately from other prescriptions and OTC’s inside a locked containers within a locked enclosure. (2 locks)
6. Shift counts must take place in all facilities with shift change
7. In facilities without shift change controls should be counted and documented at least once daily.
8. **Must check count accuracy by comparing the amount of medication present, comparing that count to BOTH previous count and the number of doses administered between the counts.**
9. New regulations create a shift count log that must be used for documentation

**VIII. DOCUMENTATION AND RECORD KEEPING**

1. Can either use an agency approved MAR or an alternative (provided by pharmacy) as long as it provides the same information
2. **Must include the prescriber’s name for each medication**
3. Requires a standard legend that includes:
   - 1 = home
   - 2 = work
   - 3 = ER/hospital
   - 4 = refused
   - 5 = medication not available
   - 6 = held by MD
   - 7 = other

**IX. OFF-SITE MEDICATION ADMINISTRATION**

1. If a client will be outside of the facility during a medication pass the “medication assistance provider” must:
   a. provide an adequate amount of medication for administration of all dosages the client requires while away
   b. document a count of medication being released and returned so that administration can be reconciled
   c. medications cannot be transferred to a weekly pill organizer or otherwise co-mingled unless the clients primary provider determines that the client is able to self administer that medication without supervision. In that case only the client, the client’s family or a legal guardian may transfer the medication from the original container
   d. **Must use an “Off Site Medication” form provided by the agency**
CHAPTER 65G-8 REACTIVE STRATEGIES

65G-8.001 Definitions
65G-8.002 Approved Emergency Procedure Curriculum
65G-8.003 Reactive Strategy Policy and Procedures
65G-8.004 Initial Assessments
65G-8.005 Authorizations for Specific Reactive Strategies
65G-8.006 Limitations on Use and Duration of Reactive Strategies
65G-8.007 Seclusion and Restraint
65G-8.008 Chemical Restraint
65G-8.009 Prohibited Procedures
65G-8.010 Documentation and Notification
65G-8.011 Access to Rules
65G-8.012 Enforcement

65G-8.001 Definitions.

(1) “Approved emergency procedure curriculum” means a course of instruction in procedures and techniques for intervening in behavioral emergency situations, approved by the Agency for Persons with Disabilities (“Agency”), and incorporated into a facility’s or program’s policy for utilizing reactive strategies.

(2) “Authorized staff person” means an employee of a facility or program that has completed training in the approved emergency procedure curriculum and is approved by the authorizing agent to use restraint and seclusion procedures.

(3) “Authorizing agent” means an individual authorized by the facility or program manager to approve use of a reactive strategy.

(4) “Behavioral protective device” means a device used as a means of interfering with or preventing specific results of a targeted behavior as part of a behavior program approved by the Local Review Committee.

(5) “Chemical restraint” means the use of medication to effect immediate control of an individual’s behavior. It does not include the medication administered as treatment for a medical or psychiatric condition.

(6) “Client” means any person with a developmental disability receiving services in the State of Florida.

(7) “Containment” means immobilizing an individual with any technique for the purpose of behavioral control.

(8) “Facility” means a residential operation serving Agency clients funded or licensed under Chapter 393, F.S., and includes separate and secure facilities serving forensics clients pursuant to Chapter. 916, Part III, F.S.

(9) “Implementation plan” means an individualized plan utilizing services to assist a client with developmental disabilities in acquiring skills that enable the client to improve his or her physical, mental, and social functioning.

(10) “Licensed medical professional” means a physician licensed under Chapter 458 or 459, F.S.; or registered nurse, licensed practical nurse, or Advanced Registered Nurse Practitioner licensed under Chapter 464, F.S.

(11) “Local Review Committee” means the committee required by subsection 65G-4.008(3), F.A.C., to oversee and review all behavior analysis services provided to clients to ensure that the services are designed and approved in accordance with Florida Statutes and agency rules.

(12) “Manual restraint” means the use of hands or body to immobilize a person’s freedom of movement or normal access to his or her body for more than fifteen continuous seconds. It does not include physically guiding a client during transport or skill training for up to two minutes. Repeated applications and releases of manual restraint in order to circumvent the fifteen-second and two-minute criteria are prohibited.

(13) “Mechanical restraint” means a physical device used to restrict an individual’s movement or restrict the normal function of the individual’s body. The definition does not include the following:

(a) Medical protective equipment as defined by this rule;

(b) Physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests;

(c) Devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling out of a wheelchair; or

(d) Equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs.
(14) “Medical protective equipment” means health-related protective devices prescribed by a physician or dentist for use during specific medical or surgical procedures, or for use as client protection in response to an existing medical condition.

(15) “Reactive strategies” means the procedures or physical crisis management techniques of seclusion or manual, mechanical, or chemical restraint utilized for control of behaviors that create an emergency or crisis situation.

(16) “Seclusion” means enforced isolation or confinement of an individual in a room or area. It does not mean “time out” or “time out from positive reinforcement” procedures as defined by this rule, or isolation resulting from medical conditions or symptoms of illness.

(17) “Time out” or “time out from positive reinforcement” means a procedure designed to interrupt a specific behavior of an individual by temporarily removing that individual to a separate area or room, or by screening him or her from others, or by signaling that the individual is in “time out.” “Time out” is not a reactive strategy regulated by these rules. “Time out” procedures differ from the reactive strategy of seclusion through the following characteristics:

(a) A “time out” is of short duration, as brief as one minute and never longer than twenty consecutive minutes;
(b) It is implemented only in response to a specified behavior;
(c) It is part of a written program that includes a functional assessment and is approved by a Local Review Committee; and
(d) The program is implemented either by a Certified Behavior Analyst certified by the Behavior Analyst Certification Board®, Inc.; a behavior analyst certified by the Agency pursuant to Section 393.17, F.S. and Rule 65G-4.003, F.A.C.; a psychologist licensed under Chapter 490, F.S.; or a clinical social worker, mental health counselor, or therapist licensed under Chapter 491, F.S.
(e) “Time out” data is collected for assessment, evaluation, and analysis;
(f) It is not used as a disciplinary act, threat, or as a tool for staff’s convenience;
(g) A termination criterion (e.g., “one minute of calm”) ends the time out period, ensuring that termination of the time out is under the control of the person in time out; and
(h) After termination, the individual returns to his or her previous activity.

NOTE: Use of time-out for a period exceeding twenty minutes constitutes the reactive strategy of seclusion.

Specific Authority 393.501, 393.13(4)(h)2., 916.1093(2) FS. Law Implemented 393.13(4)(h), 916.1093(2) FS. History–New 8-7-08.

65G-8.008 Chemical Restraint.

(1) Chemical restraint is used for behavioral control; it is not standard treatment for medical or psychiatric conditions.

(2) An individual may be given a chemical restraint only on the written order of an authorized physician who has determined that the chemical is the least restrictive, most appropriate alternative available.

(3) The authorizing physician either must be present at the onset of the emergency requiring restraint, or must provide telephone consultation with an authorized staff person who is present and has personally examined the individual.

(4) If the authorizing physician is not present to write the order, he or she must dictate the order’s contents to another on-site licensed medical professional;

(5) An order for chemical restraint must be recorded in the individual’s record on the same date it is issued, along with the expected results of the medication and a detailed description of the behaviors that justified the use of chemical restraint.

(6) A licensed medical professional must conduct a face-to-face evaluation of the individual within one hour of administration of a chemical restraint, if the restraint was ordered by telephone. The medical professional must record the results of this evaluation in the individual’s record and document whether the administration of medication achieved the expected results.

(7) Staff must monitor an individual who has been chemically restrained at least once every half-hour and record the effects of the restraint in the individual’s record.

Specific Authority 393.501, 393.13(4)(h)2., 916.1093(2) FS. Law Implemented 393.13(4)(h), 916.1093(2) FS. History–New 8-7-08.