Frequently Asked Questions from the

OHR Statewide Training Series

General

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 DBHDS**.
        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 OHR, in conjunction with the State Human Rights Committee (SHRC), is preparing to implement HR Access. The HR Access initiative is designed to increase accessibility for the Individuals within our service delivery system – 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.

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, which extends to making overall life decisions. Providers are still responsible for maintaining a safe and therapeutic service environment, though, 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. Everyone should have the opportunity to learn from their life decisions.

The Human Rights Regulations: A Training for Trainers

1. **What OHR information should be listed on the rights poster?**
    - At minimum, the name of the assigned Regional Advocate (for the region of the specific service location) and their telephone number should be documented on the rights poster.

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?**
    - As documented in 12VAC35-115-146, an "attorney in fact" may be considered an authorized representative and it becomes the provider's responsibility to "obtain consent for those decisions for which the individual lacks capacity" from the attorney in fact if in fact they have been "empowered to consent or authorize the disclosure under the terms of a durable power of attorney."

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.

6. **Can a guardian limit an Individual from accessing their 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."

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?**
    - 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 CRIS: 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 this chapter, 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.

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.

Investigating Abuse & Neglect: An Overview for Community Providers

1. **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. The HRR, nor the OHR, mandates how a Provider conducts abuse and neglect investigations.
    - 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.

2. **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.

3. **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.
    - 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.

4. **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.

Restrictions, Behavioral Treatment Plans, & Restraints

1. **Is a licensed behavior analyst considered a "licensed professional"?**
    - No. Per 12VAC35-115-30, "a licensed professional is either 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."

2. **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."

3. **How long does it take to get a response or confirmation for LHRC review?**
    - This timeframe is variable. Please make sure that you are conferring with your assigned Regional Advocate or Human Right Advocate for **all** restrictions being imposed on Individuals served.

4. **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.

5. **Can restrictions be imposed prior to LHRC review?**
    - LHRC review of the restriction(s) may occur after the implementation of the restriction(s). However, all restrictions should be discussed with the Individual prior to implementation.
    - Moreover, and most importantly, your Human Rights Advocate must be informed of the restriction(s). The Advocate must be notified of proposed restrictions to assured rights under Dignity (12VAC35-115-50) and the reasons for the proposed implementation, must be made to the Advocate **PRIOR** to implementation. If LHRC review occurs after a restriction has been implemented, the Provider must ensure the restriction is justified

and carried out according to sections 50 and/or 100 of the Human Rights Regulations (HRR).

6. **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; and, to ensure the restriction, if imposed, does not conflict with the HRR.

7. **Please provide clarification on the use of PRN medications, related to standing orders, in regards 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.

8. **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 the protective equipment or support does not require LHRC review as it is considered to be for protective purposes and therefore not a restraint.

9. **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.

10. **Which type of Providers may implement program rules?**
    - Any Provider (e.g., residential, inpatient, community) may implement program rules. 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. The rules or expectations should be developed to outline how Individuals should behave and interact with each other to maintain order and safety within the program setting. Providers must get as much feedback and suggestions about the program rules from those Individuals who will be expected to follow the rules.

11. **Do the LHRC Review forms have to be redacted?**
    - Any form, including the LHRC Review forms, should be submitted redacting all PHI/PII. Please consult your assigned Regional Advocate for instructions on the method used to code the forms for tracking purposes.

12. **If a parent or guardian restrains their own child or Individual they are responsible for, is the restraint reportable to the OHR?**
    - Only Providers licensed, funded, or operated by DBHDS are subject to the HRR. Therefore, any person who is not employed by a DBHDS Provider is not subject to the HRR.
    - However, all DBHDS Providers are mandated reporters and must comply with state laws governing the reporting of abuse and neglect.