

Eastern Virginia Local Human Rights Committee  
Emergency Meeting  
St. Mary's Home for Disabled Children  
July 7, 2008

An emergency executive session was held on this date at 10:05 a.m., at St. Mary's Home for Disabled Children, to review two behavior plans for resident # 1 for use of naltrexone and resident #2 for a plexiglass area, pursuant to Virginia Code 2.2 3711 (A) 4 for the protection of the privacy of individuals in personal matters not related to public business, namely for the purpose of hearing of behavior modifications pursuant to the regulations.

In attendance were: Willie Barnes, LHRC Human Rights Representative; EVLHRC committee members: Marcia Kennedy, Jeff Kail and George Amory. In addition were St. Mary's staff members: Sheri Mantoni and Robin Geluso, QMRP; Ann Sparkman, HIM; Melanie Perez-Lopez and Social Worker; Tara Dean, Primary Nurse.

Jeff Kail, Chairperson, called the meeting to order. Marcia Kennedy, member, moved to go into Executive Session and this motion was seconded by George Amory, Vice-Chairperson.

First plan reviewed was for resident #1. Jeff Kail asked the class of drug and Ms. Dean got the PDR and gave the information regarding this. The plan was approved and will be reviewed at the next regularly scheduled meeting in August, 2008.

Second plan was reviewed for resident #2 and the plan was approved with these changes:

- a sensor will be added to the door and door will have a non-locking latch;
- weather stripping may be added under the door;
- extra supports may be required on 8 foot wall;
- staff checks on the resident will be specified in the plan (minimum of every 2 hours).

The plan was approved with these changes and will be reviewed at the next regularly scheduled meeting in August, 2008.

The committee then certified that, to the best of each members' knowledge, only private business matters lawfully exempted from statutory open meeting requirements and only private business matters identified in the motion to convene the executive session were discussed in executive session. This motion was made at 10:47 by Kennedy and seconded by Amory after coming out of closed session. A motion was then made to approve both plans, one with changes. Meeting was adjourned at 10:50 a.m.

A motion was made by Marcia Kennedy at 10:47 a.m., and seconded by George Amory to reconvene in open session. Upon reconvening in open session, each member of EVLHRC certified that, to the best of each member's knowledge, only public business matters identified in the motion to convene the executive session were discussed in the executive session.

The emergency Executive Session meeting was adjourned at 11:00 a.m.

Melanie Perez-Lopez  
Director of Social Work  
St. Mary's Home for Disabled Children

## Behavioral Treatment Plan

**Name:** J. G.

**Date of Birth:** 5/17/00

**Date of Plan:** 6/26/08

**Date of Review:**

**Diagnosis:** Developmental Delay, Failure to Thrive, CP, Self Abusive Behavior, Microcephaly, s/p Gastrostomy Tube, Seizures, s/p Lithotripsy, Incontinence of Feces, Urinary incontinence.

**Medication to treat self abusive behaviors:** Naltrexone 50 mgs Q AM

**Medication to treat erratic sleep:** Melatonin 4.5 mgs at 2000  
Chloral Hydrate 500 mgs Q HS

**Criteria for reduction: Self-Abusive biting:** Plan will be considered successful when self-abusive biting behavior is reduced to zero occurrences for 2 consecutive months.  
**Erratic Sleep Pattern:** To create a regular sleep pattern-asleep by 9-10:00 at night, sleeping through the night and easy arousal in the morning at 7-8:00am.

**Target behavior:** Biting forearms and legs  
Hitting self in the head  
Erratic sleeping pattern at night

**Clinical Rational:** J was admitted on 11/29/06. At that time she was biting herself on her forearms and legs, causing bruising and open areas. She was also not sleeping well during the night, waking up and staying awake at night and sleeping excessively during the daytime. Initially it was thought that J was simply exhausted due to all of the changes in her life. Slowly she began staying awake more during the day but continued to have erratic sleep patterns at night. On several occasions, she woke from sleep screaming and crying requiring much comforting and reassurance before she was able to calm down.

A formal, non-restrictive behavior plan was written on 1-24-07 to address her self-abusive behaviors and erratic sleep patterns. This plan included a structured routine and the use of ignore/redirect techniques when J exhibited the biting behavior. Data was collected 24 hours a day on self abusive biting and sleeping patterns. Self-abusive behaviors decreased and sleep patterns improved. On 2-26-08, after two 30-day periods of significant decreases the formal plan was discontinued and the strategies from that plan were incorporated into her Activities of Daily Living. In March 2008, her sleep dropped almost 25% and she began hitting herself. In April, her sleep improved and her hitting decreased but remained significant. Hitting behavior has continued to increase. On 5-17-08, a 1 -1 weekend schedule was initiated which included a variety of positive sensory opportunities and 1 – 1 interaction from 7am – 11am, 1pm – 4pm and 6pm – 9pm. The 3-5-08 intervention strategies remained in effect. In June, J began

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biting herself again and data collection was started to monitor that behavior. In March, her diet was reviewed and Melatonin was prescribed to help regulate her sleep patterns. In April, she was treated for Sinusitis/URI and Strep. In May, Zantac 70 mg BID and Chloral Hydrate were prescribed. In June, J began biting herself again and data collection was started to monitor that behavior. She was checked several times for urinary tract infections, had a complete blood work-up and was tested for pinworms. The UTI checks were negative; the blood work did not reveal any problems and the pinworm results are not in yet. We have not been able to determine any medical reason for J's recent addition of hitting behavior and the return and increase of self-biting behavior. J's dad has been informed of her increased behaviors and is in agreement with the changes to help decrease her self-abusive biting and hitting.

**Treatment Method:** Medication in conjunction with a structured routine and use of ignore/redirect techniques when J exhibits the target behaviors of biting or hitting. Manual hold may be used to right and/or left hand for up to 2 minutes followed by another attempt at redirection and additional 2 minute holds if necessary during Behavioral Intervention Strategies. Implementation of a standard bed time routine to reduce erratic sleep.

**Data Collection:** Data will be collected 24 hours a day on self abusive biting, hitting and sleeping pattern by all staff working with J.

**Staff Training:** All staff working with J will be trained on this plan and data collection.

**Review:** Data on behaviors and sleeping will be reviewed daily by the QMRP and graphed monthly.

**Medication Plan:**

Medications will be administered as prescribed by the physician in conjunction with a behavioral treatment program.

The physician will review the medication every 90 days. Additional review will be conducted in response to changes in the frequency of the target behaviors or the development of harmful side effects. Adjustment in the dosage of medication may be necessary.

Risks of the medication have been addressed and the side effects are spelled out in the plan. J is at risk for injury due to self-abusive behaviors.

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The benefits of the medication are that her self-abusive behavior will be reduced and she will prevent further injury to herself.

**Side Effects:**

**Naltrexone:** Vomiting, nausea, convulsions, paraesthesia, grand mal convulsion, agitation, hallucination, tremulousness, dyspnea, respiratory depression, hypoxia, sweating, hypertension, hypotension, hot flashes or flushing.

**Program Steps:**

**Reduction of Self Abusive Biting and/or hitting-**

1. J will be provided with a structured routine during the day.
2. When J begins to exhibit self-abusive biting and/or hitting, staff will back off on the activity currently being offered, ignore the self-abusive biting and/or hitting and redirect J to an activity she is known to enjoy.
3. J enjoys vibration, the sound of staff making silly noises and or talking in a very deep voice, having her arms moved up and down quickly while staff make a silly noise and fast, quick, vestibular stimulation, such as staff moving her in her wheel chair (rocking or turning in circles) staff sitting J in their lap and rocking her. When J is on the mat or in her bed, she likes to have her legs moved up and down in a "bicycle" motion. There are also cassette tapes available in her classroom and living unit that she enjoys and will help her calm down.
4. Once J is calm and reassured, staff will return to the initial activity and encourage J to participate.
5. If J is in her wheelchair, staff should ensure that she has a tray toy on her wheel chair tray at all times except for meals. If the tray toy is removed for table top activities, the toy should be replaced once the activity is finished.
6. In the morning, J enjoys visiting in the other children's living units. This allows her socialization and provides her with stimulation while waiting to go to school.

**Reduction of Erratic Sleep at Night:**

1. J will be provided with a regular night time routine.
2. At bed time, staff will provide J with evening hygiene and put on her pajamas. During this time, staff should be talking softly to J and working slowly with her. This is a time for J to relax after a long day, she should not be provided with activities that will stimulate or excite her.
3. Staff should sit with her in the rocking chair and rock her slowly for a few minutes before placing her in bed.

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4. J will be placed in bed, covers pulled up, lights dim and her bed time tapes should be playing.

**When J wakes up in the middle of the night and is agitated;**

1. Check and make sure her diaper is dry.
2. Pat her back and try to lull her back to sleep
3. Sit with her in the rocking chair and try to rock her back to sleep
4. There is a vibrating pillow in her room. Give that to her to help soothe her.
5. Make sure there is quiet music playing and the lights are low.
6. There is pudding and juice in the med room. Offer her some pudding or juice.  
She may be hungry or thirsty.

If she wakes up and is lying there quietly, give her some time to drift off to sleep again.

If she continues to stay awake follow the above suggestions.

## Restrictive Behavior Plan

**NAME:** K M  
**DATE OF BIRTH:** 10/25/99  
**DATE OF PLAN:** 07/01/08  
**DATE OF REVIEW:**

**DIAGNOSIS:** Developmental Delay, Spastic Quadriplegia CP, GER, BPD, Optic Atrophy, Severe/Profound Hearing Loss (L) Ear, S/P Gastrostomy/Nissen, S/P Trache, Severe Hypoxic Ischemic Encephalopathy, Tracheobronchomalacia, S/P Left Lower Lobectomy, PDA, S/P Myringotomy, Dysphagia, Incontinence of Feces, Urinary Incontinence, MRSA, Spasticity

**MEDICATIONS:** Albuteral, Pulmicort, Cert-Vite Liquid and Vitamin D

### GOAL

To allow K increased opportunities for engagement in activities he finds enjoyable and to promote his independence, while ensuring his supervision and safety.

### OPERATIONAL DEFINITIONS

Use of plexiglass living/play area to promote independence and mobility while ensuring his supervision and safety.

To reduce or eliminate the frequency of inappropriate behaviors. Symptoms of inappropriate behaviors are defined as the following behaviors:

1. Putting hands in mouth and slinging saliva
2. Slouching and stiffening up when transitioning to wheelchair
3. Bucking, standing or rocking in his wheelchair in an unsafe way
4. Flailing and hitting others
5. Kicking

**RESTRAINT:** Plexiglass living/play area

### CLINICAL RATIONALE:

K can be very active and sometimes behave in an unsafe manner- he must be supervised closely, and should be encouraged to be safe. Safety and supervision are major concerns especially because he is trache dependent. In May of 2003, K had to be transitioned from a small crib to a large crib because he was bouncing up and down on his knees. In February 2004, several requests were made to have straps for K's feet on his wheelchair due to him getting his feet caught in the wheels and pushing off the walls. It was decided that a foot bucket would be the best way to keep him safe during transportation. On 3-2-04, strategies and goals were put into place for use while K propels his wheelchair. The wheelchair tray was changed to a smaller one so that he will be able to work on propelling activities.

In May of 2004, an IDT meeting was held to discuss K being frequently frustrated and throwing tantrums. He becomes easily bored and will bounce his wheelchair across the floor. It was decided at that time that one to one interactions would be pursued for weekends. Mats would be available in his living unit for free time out of his chair and communication symbols would be added to his wheelchair tray to help him express his wants and needs.

IDT meeting held 12/21/04 for concerns about K's activity when in bed. He enjoys playing and tumbling in bed and can become tangled in his equipment cords. It was reported to staff that

when he is awake and under direct supervision that his apnea monitor could be removed so that he could play without becoming tangled. In July 2005 and IDT Meeting was held to discuss K sliding down in his chair and making himself unsafe. Strategies to deal with inappropriate behaviors were put in place and he was made "wheelchair for transport only". In May of 2006, an IDT meeting was held to address K standing in his crib, bouncing and being unsafe. It was decided that one to one schedule would be revised and staff would try to provide more frequent

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outings. K was transitioned into a Hi-Lo bed in early 2007 due to safety concerns. Bedtime and morning routines were developed and he was given a T.V. with a variety of movies for him to choose from. T.V. time was incorporated into his routines and he really seemed to enjoy the new activity. On 7/19/07, IDT meeting held to discuss increase in mouthing/spit throwing and to address consistency in routine. A creative playroom will be created to give K more time out of his chair and the ability to play during down time. More specific interventions were put out to staff to address inappropriate behaviors. The playroom is no longer used because of its location. IDT Meeting held on 11/27/07 to discuss more one to one staff on the weekends and Infection control concerns because child plays on the floor in evening program. It was decided that the carpet could be sprayed after he is finished playing to eliminate infection control concerns and one to one schedule would be increased to include staff in the morning on the weekends.

In March of 2008, an IDT meeting was held to address behavioral support needs. Discussed were mobility and safety, ease of transitions, inappropriate behaviors and sensory integration. The outcome of the meeting included to develop weekend routines to include sensory strategies and how staff should respond. The stander will be used for weight bearing and to increase calming prior to transition in the evening and activities will be developed for him to use while in the stander. Look into the ability for K to get outside more and to continue to provide more consistent one to one staffing.

K continues to have periods of one to one staffing in order to provide safe opportunities for independent play and gross-motor challenging. His school PT has tried various sensory integration activities, such as weighted blankets, wrist weights, etc. to see if these activities would help him remain calmer during his daily schedule. He sometimes has a temporary calming period, but the overall impression is that these techniques have provided inconsistent and minor effects. The Psychological Evaluation done on 2/26/08, places K's functioning at or below a 2 year level for all areas evaluated with significant strengths in cognitive functioning and social interactions skills. His significant weaknesses are in adaptive behavior and expressive communication. Communication was seen as the main factor affecting K. His current IEP addresses communication and is working toward teaching him how to use his hands to communicate via simple signs. K has been following directions better, answering yes/no questions correctly more consistently, and anticipating what particular people will be doing to assist him. A variety of equipment (such as the stander, kneeler, wheelchair that he is able to use his feet to push around, the bronco and the tricycle) have been used as additional positions to the regular wheelchair. On 6/19/08 an IDT meeting was held and it was decided to try the use of a living/play area to give K more time for safe independent play.

The Guardian/Power of attorney has remained very involved since obtaining custody. He has attended all meetings, helped to develop strategies and visits regularly. He was notified about this plan. He supports the plan to promote independence and safety and will sign the plan prior to the Human Rights Meeting. Attempts have been made to reach his Grandmother and have been unsuccessful.

#### **TREATMENT METHOD**

Use of Plexiglass living/play area, structured routines and ignore/redirection

**DATA COLLECTION**

Data will be collected 24 hours a day on inappropriate behaviors by all staff working with K. Data collection sheets are located in the Classroom and living unit. The frequency of the target behaviors will be graphed monthly.

**PROGRAM STEPS/REDUCTION OF INAPPROPRIATE BEHAVIORS**

1. The following activities have been identified as enjoyable to K:
  - Reading adapted books (adapted so he can more easily turn pages)
  - Free play on floor (likes to crawl on small benches, go under mat tables, etc.)
  - Playing in his tent or tunnel in the CR
  - Walking with assistance

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- Take a walk or play on the ground outside, if a nurse is available
  - Standing, tumbling in bed
  - Watching movies
  - Playing "copycat" games (he mimics what you do, and vice versa)
  - alone time (he can become very overwhelmed during group activities and needs to move away)
2. Keep K's schedule as routine as possible (follow schedules already in place). He shows fewer behaviors when he knows what is happening and what will happen next.
  3. Be firm with his schedule and always have something for Kishaun to do. There is a clear connection between boredom and hand-mouthing.
  4. Make sure that use of the T.V. is a scheduled part of his day. The T.V. should be turned off at specific times, and he should be warned in advance that T.V. time is almost over. Always immediately have something else for him to do when it is time to turn the T.V. off.
  5. K will use the plexiglass living/play area during AM and PM free time and when he is in his room and there are no scheduled activities. He will continue to be supervised while in the living/play area.
  6. He should be provided with a variety of activities that he enjoys. If one to one staff is available, they should play with K and provide him choices of activities to participate in. Other one to one activities with K should be offered to see if he would like to participate in them or stay in the living/play area.
  7. The first step staff should take if K is showing an inappropriate behavior is to redirect him to participate in an appropriate behavior.
  8. If he continues the behavior after you have tried to redirect him, you should ignore the behavior and continue to redirect him to a more appropriate behavior with out giving K eye-contact. It is critically important that you do not acknowledge the behavior.
  9. Make sure that K gets plenty of positive attention and is given as many opportunities as possible to make choices in his routine (by using eye gaze, answering yes/no questions and simple signs) so he will not need to use inappropriate behaviors in order to get attention or exert his independence.

K is at risk for injury if he does not have a safe area to play. He has fallen in his chair recently from bouncing and rocking. While in the living/play area, he could potentially bang his head, bump into it, pinch his fingers in the hinge of the gate and mouth on the plexiglass. All of these things have been taken into account and will be monitored. He will continue to be supervised while in the living/play area. The plexiglass living/play area was designed so that K would be visible to staff while he was playing and it has a door for easy entry and exit.

The benefits of the living/play area are that inappropriate behaviors will be reduced and K will have a safe area where he can independently play.

#### **STAFF TRAINING / MONTHLY REVIEW**

1. All staff will receive in-service in the above procedures prior to their implementation.
2. Initially, the Facility QMRP will review documentation daily to ensure accuracy of restraint usage, and documentation.

