**Peer Review Committee (PRC)**

**Intensive Positive Behavior Support Plan (IPBSP) Checklist**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  |  | Date: |  |
| Author: |  |  | Credentials: |  |
| Date of Plan: |  |  | Date of Emergency Implementation: |  |
| New plan [ ]  Review [ ]  | Date of last PRC review: |  Behavior Safety Plan is Attached [ ]  |

**Required Elements of Intensive Positive Behavior Support Plan** (*Full requirements may be found in the Department of Developmental Services Regulations 115 CMR 5.00* [*https://www.mass.gov/regulations/115-CMR-500-standards-to-promote-dignity-0*](https://www.mass.gov/regulations/115-CMR-500-standards-to-promote-dignity-0) *)*

*Does the Plan Being Presented to the PRC Contain These Required Elements?*

|  |  |  |  |
| --- | --- | --- | --- |
| **I. Identifying Information** | **Incomplete** | **Yes** | **No** |
| A. Name |[ ] [ ] [ ]
| B. Date of Birth |[ ] [ ] [ ]
| C. Age |[ ] [ ] [ ]
| D. Day Location |[ ] [ ] [ ]
| E. Residential Location |[ ] [ ] [ ]
| F. Clinician’s Name, Degree, Licensure, Title |[ ] [ ] [ ]
| G. Is the author of the plan a PBS qualified clinician? If no, supervising PBS qualified clinician must be present at PRC meeting. |[ ] [ ] [ ]
| H. Agency name, address, phone number, email |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **II. Functional Behavior Assessment (FBA): Rationale for Design of the Plan** | **Incomplete** | **Yes** | **No** |
| A. Sources of information for FBA are listed (assessors, indirect/direct tools, date(s) completed) |[ ]  ☐ | ☐ |
| B. Is the FBA current, and based on available data with conclusions derived from that data?  |[ ]  ☐ | ☐ |
| C. Brief summary of the individual’s psychosocial history, strengths, areas of success, life concerns, relevant disabilities, challenging behaviors, medications, medical/physiological/organic issues; etc. |[ ]  ☐ | ☐ |
| D. Competing Pathways: for each response class, setting events, antecedents, operationally defined challenging behavior(s), maintaining consequences, identified function, desired behavior, functionally equivalent replacement behavior(s) are listed |[ ]  ☐ | ☐ |
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **III. Rationale for Plan** | **Incomplete** | **Yes** | **No** |
| A. Reasoning for need for I-PBSP. Is there a description of the reasons why universal and targeted supports were not sufficient? |[ ] [ ] [ ]
| B. History of less intrusive interventions given |[ ] [ ] [ ]
| C. Date of plan, date(s) of revision  |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **IV. Behaviors to Decrease** | **Incomplete** | **Yes** | **No** |
| A. Clear specification of all behaviors the plan seeks to decrease. |[ ] [ ] [ ]
| B. Operational definitions of all behaviors targeted for decrease. |[ ] [ ] [ ]
| C. Clear specification of the methods by which targeted behaviors will be measured (frequency, severity, duration, etc.) |[ ] [ ] [ ]
| D. Baseline and current data for all behaviors. |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **V. Replacement Behaviors** | **Incomplete** | **Yes** | **No** |
| A. Clear specification of functionally related alternative behavior(s). |[ ] [ ] [ ]
| B. Operational definitions of all behaviors targeted for increase. |[ ] [ ] [ ]
| C. Clear specification of the methods by which targeted behaviors will be measured (frequency, severity, duration, etc.) |[ ] [ ] [ ]
| D. Baseline and current data for all behaviors. |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **VI. Protocol for Acquiring and Maintaining Replacement Behaviors**  | **Incomplete** | **Yes** | **No** |
| A. Adequate provision of positive reinforcement. |[ ] [ ] [ ]
| B. Intervention(s) to increase frequency of replacement behavior(s) |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **VII. Interventions** | **Incomplete** | **Yes** | **No** |
| A. Well-defined preventative interventions (such as: environmental modifications, scheduling changes, antecedent modifications, or procedures to attenuate motivating operations effects). |[ ] [ ] [ ]
| B. Clear identification of all restrictive interventions leading to the need for an I-PBSP. |[ ] [ ] [ ]
| C. Conditions in which interventions are applied. |[ ] [ ] [ ]
| D. Duration of intervention per application, if applicable. If time out is included in the plan, it must not exceed 15 minutes. |[ ] [ ] [ ]
| E. Objective criteria for termination of intervention, if applicable. |[ ] [ ] [ ]
| F. Interventions are based on the results of the FBA and are evidence-based, least restrictive, and most appropriate. |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **VIII. Monitoring of Plan** | **Incomplete** | **Yes** | **No** |
| A. Provide procedures for monitoring, evaluating and documenting each of the interventions in the plan. |[ ] [x] [ ]
| B. Clear statement of how the treating clinician will oversee implementation of plan (i.e., training, frequency of target behaviors, frequency of interventions, safety checks, reinforcement data, and documentation required to comply with the provisions of plan). |[ ] [ ] [ ]
| C. Criteria that define the need to revise plan and the steps to do so. Are the prevention, teaching, and response strategies sufficient to move an individual to a lower tier of support? Statement of how often clinician will monitor and amend as needed. No more than 60 days? |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| **IX. Risks**  | **Incomplete** | **Yes** | **No** |
| A. Identify the risks for physical and/or psychological harm to the individual for each intervention. |[ ] [ ] [ ]
| B. Does this person also have a separate DDS Risk Plan? (This question is for tracking purposes and does not stipulate that a DDS Risk Plan is required.) |[ ] [ ] [ ]
| Notes/Comments: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **X. Consent and Approval** | **Incomplete** | **Yes** | **No** | **DATE** |
| A. Informed Consent by INDIVIDUAL and/or LEGALLY AUTHORIZED REPRESENTATIVE |[ ] [ ] [ ]   |
| B. Review and approval by Senior PBS Qualified CLINICIAN. |[ ] [ ] [ ]   |
| C. Review and approval by HUMAN RIGHTS COMMITTEE. Or scheduled date |[ ] [ ] [ ]   |
| C. PHYSICIAN review of plan as indicated\*, and determination that none of the interventions are medically contraindicated. (\*For specific plans pursuant to 115 CMR 5.14A) |[ ] [ ] [ ]   |
| D. Copy of head of program’s emergency approval if needed. |[ ] [ ] [ ]   |
| Notes/Comments: |

**XI. Decision:**

|  |
| --- |
|[ ]  Approved |
|[ ]  Approved with the following changes: |
|[ ]  Not approved |
|[ ]  Further Information requested: |

|  |
| --- |
| **Other Evaluations/Recommendations to Consider:** |
|  |

|  |  |
| --- | --- |
| Date of next review: |  |

**Participating Peer Review Committee Members:**

**(If meeting in-person, initial next to name; if meeting virtually, complete roll call)**

|  |  |  |
| --- | --- | --- |
| Peer Review Chairperson and PBS Qualified Clinician |  |  |
| PBS Qualified Clinician, Licensed Psychologist |  | PBS Qualified Clinician |
| PBS Qualified Clinician |  |  |