

OFFICE OF ADMINISTRATIVE HEARINGS

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Chief Administrative Law Judge of the Office of Administrative Hearings, pursuant to the authority set forth in Section 8 of the Office of Administrative Hearings Establishment Act of 2001, effective March 6, 2002 (D.C. Law 14-76, D.C. Official Code § 2-1831.05(b)(7)), gives notice of the adoption, on an emergency basis, of the following amendments to Chapter 28 of Title 1 of the District of Columbia Municipal Regulations (DCMR).

Adoption of these rules on an emergency basis will ensure that important and necessary procedural reforms are available promptly to the parties that appear before OAH. Therefore, adoption of these rules on an emergency basis is necessary to protect public health, safety and welfare. These emergency rules were adopted on June 16, 2005, and became effective on that date. These emergency rules will expire 120 days after their adoption, or upon publication of a notice of final rulemaking in the *D.C. Register*, whichever occurs first.

The Chief Administrative Law Judge also gives notice of his intent to take final rulemaking action to adopt these rules as an amendment to Chapter 28 of Title 1 DCMR "Office of Administrative Hearings Trial Procedural Rules" in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register* in accordance with § 6(a) of the District of Columbia Administrative Procedure Act, D.C. Official Code § 2-505(a).

Section 2802.2 of 1 DCMR Chapter 28 is amended to read as follows:

2802.2 Any case commenced before this administrative court that arose exclusively from material facts underlying a contested case pending before an agency or tribunal prior to October 1, 2004, shall be commenced before this administrative court not later than 120 days after this administrative court acquires jurisdiction to hear such case, or by July 15, 2005, whichever is later.

Section 2810.2 of 1 DCMR Chapter 28 is amended to read as follows:

2810.2 Unless otherwise provided by statute or these Rules, documents may be faxed to this administrative court in a manner prescribed by the Clerk, and such documents shall be considered filed as of the date the fax is received by the Clerk. Any incomplete or illegible fax will not be considered unless a hard copy of the fax is filed, or a complete and legible fax is received, within three (3) business days of

005951

the first transmission. Upon motion, the presiding Administrative Law Judge may extend this time.

Section 2832.6 of 1 DCMR Chapter 28 is amended to read as follows:

2832.6 An order granting or denying a motion for reconsideration shall be issued within thirty (30) days of receipt of the motion.

Section 2843.2 of 1 DCMR Chapter 28 is amended to read as follows:

2843.2 As required by Federal law, 34 CFR 361.57(e)(1), decisions in cases involving Rehabilitation Services Administration ("RSA") benefits shall be issued and served upon the parties within thirty (30) days from the close of the record.

Section 2843.3 of 1 DCMR Chapter 28 is amended to read as follows:

2843.3 As required by the District of Columbia Public Assistance Act, D.C. Official Code § 4-210.12(a), decisions shall be issued and served upon the parties within sixty (60) days of receipt of the hearing request in cases involving the following public benefit programs: Temporary Assistance for Needy Families ("TANF"); Interim Disability Assistance; General Assistance for Children; Program on Work, Employment and Responsibility ("POWER"); Medicaid; and Emergency Family Shelter Services.

Comments on these proposed rules should be submitted in writing to Ms. Barbara Madden, Executive Director, Office of Administrative Hearings, 441 4th Street, N.W., Suite 870-North, Washington, DC 20001-2714, with thirty (30) days of the publication of this notice in the *D.C. Register*. Copies of these proposed rules are available without charge at that address.

005952

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Consumer and Regulatory Affairs (DCRA), pursuant to the authority under section 18 (e) of A Regulation Governing Vending Businesses in Public Space, enacted December 13, 1974, Reg. 74-39, 21 DCR 1285 as amended by section 2 (k) of the Vendors Regulation Amendments Act of 1978, effective June 30, 1978, D.C. Law 2-82, 24 DCR 9293, Reorganization Plan No. 1 of 1986, effective September 7, 1987, and Mayor's Order 87-202, effective September 10, 1987, hereby gives notice of the intent to adopt, on an emergency basis, amendments to Chapter 5 of Title 24, "Vendors and Solicitors," of the District of Columbia Municipal Regulations. The amendments will allow the Director and the Office of the Mayor to administer a pilot program for street vending for the purpose of identifying the location of each sidewalk vendor site on each block of the Central Vending Zone; reviewing the appropriateness of a vending business located within 50 feet of a store that sells the same, substantially the same, or similar goods; determining an appropriate mix of vending sites for vendors of food, fruit or flowers, general merchandise, shoe shine, and street photographers; identifying the best lottery or alternative system for matching vendors with sidewalk and roadway vendor sites; determining a two year public space rental fee for each vending site; and developing a minimum of four distinct design standards for vending stands, food carts (including ice cream), and roadway vehicles. Licenses issued under this program will be restricted to those persons who agree to sign a contract with the entity designated by the Mayor to administer the pilot program.

Emergency promulgation of these rules is required to permit the Mayor and DCRA to implement the vending demonstration zone pilot program prior to the summer tourist season. This will enable the various District agencies involved in enforcing health and safety regulations for street vendors to take immediate action under these emergency rules to better protect the health, safety, and welfare of the public. This emergency rulemaking was adopted on June 16, 2005, after a public hearing was conducted on June 15, 2005 to obtain comments on the vending demonstration zone pilot program, which may result in adding to or deleting from existing areas where vending may take place. The Director also gives notice of his intent to take final rulemaking action to adopt these rules in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*. The emergency rules will expire one-hundred twenty (120) calendar days after adoption or upon the publication of a notice of final rulemaking in the *D.C. Register*, whichever occurs first.

24 DCMR Chapter 5 is amended as follows:

Paragraph (a) of Subsection 501.4 is amended to read as follows:

005953
1

- (a) No more than three (3) sidewalk vendors shall be permitted to occupy any side of any block in the central vending zone or neighborhood commercial zone as these zones are delineated in section 515 of this chapter, except that no vending shall be allowed in the locations restricted under section 515 of this chapter, and no vending site shall be located in front of a predominately residential building. The provisions of this section shall not apply to vending designs or sites approved for evaluation by the Public Space Committee in a vending demonstration zone authorized under 501.4 (b) and 501.4 (f).

A new paragraph (g) is added to subsection 501.4 to read as follows:

- (g) Any licensed vendor operating within the geographical boundaries of the vending demonstration area approved by the Council in the request for proposals issued according to the provisions of section 501.4 (b) and 501.4 (f) of this chapter shall only operate at the space assigned to him or her under the plan approved by the Public Space Committee, and shall be required to have an approved operating agreement with the Public Space Planning and Management Corporation for the duration of the vending demonstration program.

A new subsection 510.24 is added to read as follows:

- 510.24 The provisions of this chapter shall not apply to vending designs or sites approved for evaluation in a vending demonstration zone authorized under § 501.4(b) and § 501.4 (f) of this chapter.

Subsection 512.1 is amended to read as follows:

- 512.1 The Director shall issue a request for proposals every eight (8) years to develop a minimum of four (4) distinct design standards for vending stands, food carts (including ice cream), and roadway vehicles. The initial request for proposals shall be issued within six (6) months of the effective date of the Omnibus Regulatory Reform Amendment Act of 1998. The design standards shall be adopted by regulation, after public hearing. Each vendor shall have the design of their stand, cart, or vehicle approved by the Public Space Committee of the Department of Public Works prior to new licensure or license renewal. The design of each stand or cart or kiosk operating within a vending demonstration area shall be approved by the Public Space Planning and Management Corporation as part of the operating agreement with each vendor who operates the stand or cart or kiosk at its assigned site. The Public Space Planning and Management Corporation shall not approve food carts or tables for operation on a sidewalk vending site to exceed a length of 8 feet, a width of 4 ½ feet and a height of 7 ½ feet. The provisions of §§ 512.3 through 512.12 of this chapter shall not apply to vending designs or sites approved for evaluation in a vending demonstration zone authorized under § 501.4 (b) and § 501.4 (f) of this chapter.

Subsection 515.16 is amended as follows:

The preamble "Sidewalk vending business or operation shall be prohibited on the following streets:" is deleted and the following language is inserted to read as follows:

515.16 Except for vending sites approved for evaluation in a vending demonstration zone authorized under § 501.4 (b) and § 501.4 (f), sidewalk vending business or operation shall be prohibited on the following streets:

A new subsection 515.33 is added to read as follows:

515.33 A vending demonstration area as described in the request for proposals issued pursuant to section 501.4 (b) of this chapter is hereby established within the Central Vending Zone. The demonstration area shall consist of all public space within the following boundaries:

- (a) Commencing at the building line at the southeast corner of Square 200, (H and Vermont, NW) and moving northeast along the building line parallel to Vermont Avenue, Across I Street to the centerline of 15th Street NW;
- (b) Northward along the centerline of 15th Street, past K Street, to a point where the southern building line of Square 216, if extended, would intersect;
- (c) Eastward along the southern building line of Square 216 to the centerline of Vermont Avenue;
- (d) Southward across K Street along the centerline of 15th Street to a point where the southern building line of Square 218, if extended, would intersect;
- (e) Eastward along the southern building line of Square 218, and continuing through the southern portion of Franklin Square, to the intersection of the building lines on the southwest corner of 285;
- (f) Southward across Eye Street and along the western building line of Squares 286 and 287;
- (g) Eastward along southern building lines of Squares 287, and 318 to the centerline of 11th Street NW;
- (h) Northward along the centerline of 11th Street NW to the centerline of New York Avenue NW;
- (i) Northeast along the centerline of New York Avenue NW to the centerline of 9th Street NW;

- (j) Southward along the centerline of 9th Street NW to the point where the southern building line of Square 404, if extended, would intersect;
- (k) Eastward along the southern building line of Square 404;
- (l) Northward along the western building line of Square 404 to the centerline of Eye Street;
- (m) Eastward along the centerline of Eye Street to the point where the western building line of Square 428, if extended, would intersect;
- (n) Southward along the western building line of Square 428 and 429;
- (o) Eastward along the southern building line of Square 429 to the centerline of 6th Street NW;
- (p) Southward along the centerline of 6th Street to the point where the northern building line of Square 459, if extended, would intersect;
- (q) Southwest along the northern building line of Square 459 to the centerline of 7th Street;
- (r) Northward along the centerline of 7th Street to D Street, then westward along D Street to a point where the eastern building line of Square 407, if extended, would intersect the centerline of D Street;
- (s) Northward along the eastern building line of Square 407;
- (t) Westward along the centerline of E Street to 15th Street NW;
- (u) Northward along the centerline of 15th Street NW to a point where the northern building line of Square 221 intersects;
- (v) Westward along the northern building line of Square 221 to a point where the western building line of Square 200, if extended, would intersect; and
- (w) Northeast along this line to the southeast corner of Square 200.

All persons desiring to comment on the subject matter of this proposed rulemaking should submit comments in writing to the Office of the General Counsel, Department of Consumer and Regulatory Affairs, Suite 9400, 941 North Capitol Street, N.E., Washington, D.C. 20002, not later than thirty (30) days after the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules can be obtained from the Department at the address listed above. A copying fee of one dollar (\$1) will be charged for each requested copy of the proposed rulemaking.

**DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH**

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Mental Health, pursuant to the authority set forth in sections 114 and 209 of the Mental Health Service Delivery Reform Act of 2001 (Act), effective December 18, 2001, D.C. Law 14-56, D.C. Official Code §§ 7-1131.14 and 1231.09 (2001), respectively, hereby gives notice of the of the adoption, on an emergency basis, of the following new Title 22A D.C. Municipal Regulations, Chapter 5. The new Chapter 5, entitled Use of Restraints and Seclusion, sets forth the rules regarding the use of restraints and seclusion by hospitals, residential treatment centers, site-based mental health crisis emergency programs certified by the Department of Mental Health (DMH) and DMH contracted psychiatric crisis stabilization programs, including pre-requisites for the use of restraints and placement in seclusion, documentation and monitoring requirements, staff training requirements, and post-restraint or post-seclusion actions.

Two earlier versions of these emergency and proposed rules were published on September 3, 2004 at 51 D.C.R. 8691 and December 31, 2004 at 51 D.C.R. 11863 respectively. The December 31, 2004 version of the emergency and proposed rules has been modified in response to public comments received during the comment period. Comments were received from several different parties. DMH has made the following changes to the rules in response to the written comments about the rules. The first change is a change to §501.2(c) requiring that the written order be given within one (1) hour of the initiation of restraints and seclusion in response to an emergency. The second change adds new sections 502.5 and 502.6 and requires that providers offer consumers the opportunity to document preferences about the use of restraint and seclusion during a psychiatric emergency in advance instructions. The third change to §503.6 clarifies the circumstances that apply to the use of legally mandated restraints with a concomitant change to §513. The fourth change to §505.1(i) clarifies that restraints or seclusion may not be applied without the written authorization of either the attending physician or the physician assistant. The fifth change, to §506.2(b) requires that the registered nurse (RN) document the justification for the use of restraints or seclusion within one (1) hour of the emergency order. The sixth change, to §507.2, clarifies the monitoring procedures that must be used when a consumer under the age of eighteen (18) is placed in seclusion. The seventh change to §514.6 clarifies the role of the physician assistant. The eighth change, to §515.6 clarifies that physical holds may be used with children and youth who have been sexually or physically abused. The ninth change, to §515.8 specifies the circumstances in which restraint and seclusion may be used with deaf or mute consumers. The tenth change, to §516.1 requires that providers complete and submit a major unusual report to DMH after the use of restraints or seclusion. The eleventh change, to §517.5 requires that an RN obtain an order from either a physician or physician assistant for the use of protective measures. Definitions of maximum security patients and forensic patients have been added to §599.1. The definitions of a physician assistant and RN found in §599.1 have been amended to include those persons working as commissioned public health services officers in the employment of the government of the United States.

005957

Because of the substantive changes, the rules are being republished as proposed, to allow an opportunity for further public comment. In addition, the rules are being republished as emergency rules to comply with the requirements of the Act. The Act was enacted to comply with the Consent Order in *Dixon et al. v. Anthony A. Williams, et al.* (Consent Order). The Consent Order governs the process for transitioning the newly established DMH back to the District of Columbia government and requires DMH to implement rules regarding protections for consumers of mental health services and mental health supports described in Title II of the Act.

The Act requires the Department of Mental Health to promulgate rules regarding consumers' rights prior to October 1, 2001. Currently, the District of Columbia has no rules with respect to the use of restraints and seclusion. Thus, emergency action is necessary to establish rules regarding the use of restraints and seclusion for the immediate preservation of the public peace, health, safety, welfare and morals.

These emergency rules were adopted and will become effective on their publication in the D.C. Register and will expire 120 days after that effective date.

The Director also gives notice of her intent to take final rulemaking action to adopt the proposed rules in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

Title 22A DCMR is amended by adding the following new Chapter 5:

Chapter 5

Use of Restraints and Seclusion

500 PURPOSES AND APPLICATION

500.1 The purpose of these rules is to:

- (a) Provide a safe and therapeutic environment for consumers;
- (b) Significantly reduce the incidence of emergencies that necessitate the use of restraints and seclusion;
- (c) Establish positive, trusting relationships among consumers, families of consumers, and mental health provider staff;
- (d) Employ restraints and seclusion in an emergency, only in accordance with this chapter, and other applicable federal and District laws and regulations;
- (e) Reduce and minimize the use of restraints and seclusion in an emergency in favor of less restrictive behavior management techniques;

- (f) Promote, facilitate and implement the use of consumer's advance instructions regarding treatment preferences in the event of a psychiatric emergency;
- (g) Facilitate appropriate placements and transfers for consumers, as necessary, such that the degree of control over consumers in the treatment environment reduces or eliminates the need for repeated or sustained use of restraints and seclusion in an emergency;
- (h) Promote, facilitate, and implement initial and continuing education and training programs for mental health provider staff charged with applying, monitoring, and documenting the use of restraints and seclusion in an emergency; and
- (i) Aid in the development of internal and external quality improvement processes to identify and implement ways in which the use of restraints and seclusion in an emergency may be reduced or eliminated in favor of more positive behavioral management techniques with less potential risk.

500.2 The rules in this chapter are applicable to all mental health providers in the District. For purposes of this chapter, a mental health provider (MH provider(s)) is any entity that:

- (a) Is operated, licensed, or certified by the Mayor to provide mental health services or mental health supports; or
- (b) Has entered into an agreement with the Mayor to provide mental health services or mental health supports.

500.3 Consumers have the right to be free from restraints or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

500.4 Restraints include devices and techniques designed and used to control a consumer's behavior in an emergency, as further described in §502.

500.5 Seclusion is the involuntary confinement of a consumer in a room or area where the consumer is physically prevented from leaving, as further described in §503.

500.6 An "emergency" which may require the use of restraints or seclusion occurs when a consumer experiences a mental health crisis and is presenting an imminent risk of serious injury to self or others.

500.7 Restraints and seclusion, as further described in §503 and 504 of this chapter, may only be used during an emergency by trained staff, in accordance with the requirements of this chapter, working at one of the following:

- (a) A hospital when administering inpatient or emergency psychiatric services;

- (b) A residential treatment center (RTC) certified pursuant to 29 DCMR §948 or under contract with the District to provide mental health services to District residents;
- (c) Site-based mental health crisis emergency programs certified by the Department of Mental Health (DMH); or
- (d) DMH contracted psychiatric crisis stabilization programs.

500.8 Except for the MH providers specifically identified in §500.7, restraints and seclusion may not be used by any other MH provider under any circumstances. An MH provider not specifically authorized to use restraints or seclusion must comply with the requirements of §§519, 520 and 521 of this chapter.

500.9 Restraints and seclusion shall not include:

- (a) General protective security measures including, without limitation, locked wards, or other special security measures adopted in youth residential treatment centers, maximum security psychiatric hospitals or forensic units in psychiatric hospitals, or specific security measures ordered by a court;
- (b) Time-out as further described in §504.2; or
- (c) Protective measures as further described in § 517.

501 GENERAL PROVISIONS REGARDING THE USE OF RESTRAINT AND SECLUSION

501.1 Each MH provider shall comply with the requirements of this chapter regarding the use of restraints and seclusion. Each MH provider shall have a policy addressing the use of restraint and seclusion that satisfies the requirements of §519.

501.2 Restraints or seclusion shall only be used in an emergency in compliance with the following:

- (a) The use of restraints or seclusion is, in the written opinion of the attending physician or physician assistant, necessary to prevent serious injury to the consumer or others;
- (b) Less restrictive treatment techniques have been tried or considered and determined to be ineffective to prevent serious injury to the consumer or others; and
- (c) The attending physician or physician assistant gives a written order, within one (1) hour of the initiation of either restraints or seclusion, for the use of restraints or seclusion. If the consumer's treating physician is available in

person at the time the emergency arises, he or she is deemed to be the attending physician for purposes of this chapter.

501.3 Any use of restraints or seclusion with a consumer shall be:

- (a) Implemented in the least restrictive manner possible;
- (b) Implemented in accordance with safe and appropriate techniques, which include:
 - (1) The application of restraints or placement in seclusion by trained and educated MH provider staff in a manner that is designed to prevent serious harm to the consumer or others;
 - (2) The application of restraints or placement in seclusion that is appropriate for the severity of the consumer's condition or behavior, as well as the consumer's chronological and developmental age, size, gender, physical, mental, and emotional condition, and personal history, including any history of trauma, physical, sexual or mental abuse; and
 - (3) The application of restraints or placement in seclusion such that it is assured that the consumer is allowed to maintain normal bodily processes, breathing patterns, and blood circulation during the entire time the restraint is employed.
- (c) Continually assessed, monitored, and evaluated; and
- (d) Ended at the earliest possible time.

501.4 All restraints shall be sanitized after each use.

501.5 The health and safety of the consumer are of paramount importance at all times. If a consumer demonstrates a need for medical attention in the course of an episode of restraints or seclusion, medical priorities shall supersede behavioral priorities, the use of restraints or seclusions shall be terminated immediately, and the consumer shall receive immediate medical attention.

501.6 Restraints and seclusion are not treatment modalities. Neither the use of restraints nor the placement of a consumer in seclusion shall be included as a mental health support or mental health service in a consumer's service plan. However, a service plan may address the need for a reduction or elimination of the use of restraints or seclusion in an emergency, through the use of alternative behavior management techniques or other less restrictive interventions.

501.7 Restraints or seclusion shall never:

- (a) Be used as a means of coercion, discipline, convenience, or retaliation;

- (b) Be used in any manner that obstructs the airways or impairs breathing;
- (c) Take the form of pepper spray, mace, handcuffs, or electronic devices, such as stun guns; or
- (d) Be used simultaneously with another method of restraint, unless otherwise permitted by this chapter.

501.8 An order for restraints or seclusion shall never be written in a non-emergency situation, as a standing order, or on an as-needed basis.

501.9 Restraints shall only be used in a manner consistent with the manufacturer's instructions for care and use of the devices.

501.10 The effects of and any conditions, symptoms or injuries resulting from any restraint or seclusion used with a consumer shall be documented in the consumer's clinical record.

501.11 Specific policies and procedures for employing each method of restraint and seclusion are set forth in this chapter. Any use of a restraint or seclusion on a consumer by a MH provider's staff that is not in accordance with this chapter shall constitute a violation of this chapter, and may constitute a violation of other District or federal laws or regulations.

502 CONSUMER RIGHTS REGARDING THE USE OF RESTRAINTS AND SECLUSION

502.1 All MH provider staff shall treat each consumer receiving mental health services and supports with consideration and respect for the consumer's dignity, autonomy and privacy at all times.

502.2 Each consumer shall be provided a verbal explanation of the MH provider's Restraint and Seclusion Policy at intake or the next subsequent contact with the consumer. If the consumer is a minor or a legally incompetent adult, the consumer's parent(s) or legal guardian(s) shall also be given copies of the Restraint and Seclusion Policy.

502.3 Each MH provider shall communicate its restraint and seclusion policy in a language the consumer, or the consumer's parent(s) or legal guardian(s) understand. When necessary, the MH provider shall provide interpreters or translators, including those for American Sign Language.

502.4 Each MH provider shall request consumers to sign an acknowledgement of the explanation of the MH provider's Restraint and Seclusion Policy and document the acknowledgement in each consumer's clinical record.

502.5 Each consumer shall be provided the opportunity to document his or her advance instructions regarding treatment preferences in the event of a psychiatric

emergency in accordance with the requirements of 22A DCMR Chapter 1 and DMH policy on the use of advance instructions. If the consumer is a minor or legally incompetent adult, the consumer's parent(s) or legal guardian(s) shall also be given the opportunity to document advance instructions in accordance with the requirements of 22A DCMR Chapter 1 and DMH policy on the use of advance instructions.

502.6 Advance instructions regarding treatment preferences in the event of a psychiatric emergency shall be placed in the consumer's clinical record in accordance with the requirements of 22A DCMR Chapter 1 and DMH policy.

503 RESTRAINTS GENERALLY

503.1 Restraints shall include devices and techniques designed and used to control a consumer's behavior in an emergency.

503.2 Methods of restraint that may be prescribed in an emergency for consumers receiving services from an MH provider identified in § 500.7 of this chapter include:

- (a) Four-point restraints;
- (b) Five-point restraints;
- (c) Physical Holds
- (d) Legally mandated restraints;
- (f) Medical restraints; and
- (g) Drugs used as a restraint.

503.3 Four-point restraints are the use of soft bracelets encasing the wrists and ankles of a consumer lying on a bed (face up unless medically contraindicated), which are secured to the bed frame. Only restraint devices approved by the federal Food and Drug Administration for four-point restraints may be used.

503.4 Five-point restraints are a four-point restraint with the addition of a strap, which is placed over the consumer's upper torso and under the arms and secured to the bed frame.

503.5 A physical hold is the application of physical force by a staff person without the use of any mechanical device, for the purpose of restraining the free movement of a consumer's body. A physical hold does not include briefly holding without undue force a consumer in order to calm or comfort him or her, or holding a consumer's hand to safely escort him or her from one area to another.

503.6 Legally mandated restraints are the mechanical restraint of an adult consumer during transport from a hospital to District of Columbia Superior Court or Federal Court or to a facility outside of the hospital, applied in accordance with the order of a U.S. Marshal, a judge or other law enforcement official or forensic services policy.

503.7 Medical restraints are the short-term use of physical restraint to facilitate completion of an emergency medical or surgical procedure. Medical restraint is limited to the duration of the emergency medical or surgical procedure.

503.8 A drug used as a restraint is a medication that is used to control extreme behavioral symptoms during an emergency. Drugs administered to a consumer on a regular basis as part of the consumer's regular prescribed medical regimen to treat mental, emotional or behavioral disorders or to assist the consumer in gaining self-control in accordance with the consumer's service plan shall not constitute the use of a drug as a restraint, even if the purpose of the drug is to control ongoing behavior.

504 SECLUSION GENERALLY

504.1 Methods of seclusion that may be prescribed pursuant to this chapter include the confinement of a consumer alone in a room or an area from which the consumer:

- (a) Is physically prevented from leaving; or
- (b) Believes he or she cannot leave at will.

504.2 Time out is not a form of restraint or seclusion. Time-out means a voluntary procedure used to assist consumers to regain emotional control by providing access to a quiet area or unlocked quiet room away from his or her immediate environment. A consumer who is physically prevented from leaving an area or led to believe he or she cannot leave an area at will is in seclusion, not in time out.

504.3 Seclusion is contraindicated for consumers who:

- (a) Exhibit suicidal behaviors;
- (b) Exhibit self-injurious behaviors; or
- (c) Have certain medical conditions that preclude seclusion, as determined by a physician.

505 PROHIBITIONS ON THE USE OF RESTRAINTS AND SECLUSION

505.1 In employing restraints and seclusion, the following measures are strictly prohibited:

- (a) The use of restraining nets;

- (b) Ambulatory restraints (restraints which allow the consumer to walk around while restrained, such as wristlets or anklets);
- (c) The simultaneous use of restraints and seclusion, unless the consumer is continually monitored face-to-face by a trained staff member, in accordance with the MH provider's DMH approved face to face monitoring policy;
- (d) Restraint in the prone, face-down position unless determined medically necessary by the attending physician;
- (e) "As needed" orders for restraints or seclusion;
- (f) The use of restraints or seclusion in excess of twenty-four (24) hours, unless there is a court order authorizing a longer duration;
- (g) The use of any restraint around a consumer's neck;
- (h) Covering of the consumer's face with any material or object during the process of restraint or seclusion; and
- (i) The use of unofficial restraints or seclusion, which includes any restraint or seclusion applied without the written authorization of the attending physician or physician assistant.

505.2 If an MH provider described in §500.7 intends to simultaneously use restraint and seclusion, the MH provider shall submit its face-to-face monitoring policy to DMH's chief clinical officer for review and approval. A face-to-face monitoring policy shall require a one-on-one assignment of a trained staff person to the doorway of the seclusion room for the duration of the simultaneous use of the restraint and seclusion. An MH provider shall not simultaneously use restraint and seclusion without the prior written approval from DMH's chief clinical officer of its face-to-face monitoring policy.

506 INITIATING THE USE OF FOUR-POINT AND FIVE-POINT RESTRAINTS OR SECLUSION

506.1 Unless otherwise specified in this section or in federal regulations, only a physician or a physician assistant, may order the use of restraints or seclusion. Such orders shall be in writing, except as set forth in §506.2.

506.2 In emergency situations in which a physician or physician assistant is not immediately present, a consumer may be placed in restraints or seclusion by a registered nurse (RN) before a written physician's order is obtained. In such cases:

- (a) A verbal order shall be obtained from the attending or treating physician or physician assistant and documented immediately. If a verbal order is

not obtained from the attending or treating physician or physician assistant within fifteen (15) minutes, the restraints or the seclusion shall be terminated;

- (b) The RN in charge shall document as soon as possible, but within one (1) hour of the emergency order:
 - (1) Justification for the use of restraints or seclusion;
 - (2) Alternative strategies which failed to manage the consumer's behavior or why other strategies were considered but deemed impractical or unsafe;
 - (3) The consumer's current behaviors and mental and emotional status; and
 - (4) The consumer's physical status;
- (c) The physician or physician assistant issuing the verbal order shall conduct a face-to-face assessment of the consumer within one (1) hour of the consumer being placed into restraints or seclusion; and
- (d) If the physician or physician assistant does not conduct the face-to-face assessment within one hour of initiation of the restraints or seclusion so as to confirm the initial verbal order, the consumer shall be released at that time.

506.3 The physician or physician assistant ordering the restraints or seclusion shall be available for consultation with MH provider staff throughout the period the consumer is restrained or secluded.

506.4 Any order for the use of restraints or seclusion shall not exceed the following durational limitations:

- (a) Four (4) hours for adults;
- (b) Two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; and
- (c) One (1) hour for children under nine (9) years of age.

506.5 Any orders for restraints or seclusion may only be renewed for up to a maximum of twenty-four (24) hours.

506.6 If the emergency precipitating the use of restraints or seclusion with the consumer continues beyond the limitations of the initial order, the RN shall immediately contact the physician or physician assistant to receive further instructions.

- 506.7 If the emergency precipitating the use of restraints or seclusion ends and the restraints or seclusion are discontinued before the expiration of the original order, a new order shall be obtained prior to reinitiating seclusion or reapplying restraints.
- 506.8 Any new order for the use of restraint or seclusion, or any order continuing the use of a specific restraint or seclusion for a consumer, or order for the use of a new restraint or placement in seclusion following expiration of an initial order for restraint or seclusion shall be given in accordance with this section.
- 506.9 Each written order for restraints and seclusion shall state:
- (a) The name of the physician or physician assistant giving the order;
 - (b) The date and time the written order was given;
 - (c) Whether the order was for the "initial" implementation of a restraint or placement in seclusion or the "continued" use of a restraint or seclusion;
 - (d) The specific restraints (four-point or five-point) or form of seclusion ordered, including the authorized duration of the restraints or seclusion;
 - (e) Any special instructions needed due to the consumer's medical condition, physical disability, or history of abuse;
 - (f) If required, the need for monitoring of specific medical conditions or more frequent monitoring of vital signs; and
 - (g) The behavioral criteria for discontinuation of restraints or seclusion.
- 506.10 For each order for restraint or seclusion, the physician or physician assistant shall also document in the consumer's clinical record, a note separate from the order, which shall include:
- (a) Any less restrictive techniques, such as behavioral interventions or non-physical interventions used, attempted, or considered prior to ordering the use of restraints or seclusion, as well as the reasons those techniques were not used or were ineffective;
 - (b) Whether there are any pre-existing medical conditions or any physical disabilities that would place the consumer at potentially greater risk during the use of restraints or seclusion;
 - (c) To the extent known, whether the consumer has a history of trauma, sexual, or physical abuse that would place the consumer at greater psychological risk during the use of restraints or seclusion;

- (d) The basis, including a description of the consumer's behavior and the circumstances leading to the use of restraint or seclusion, and justification for ordering the use of the specific restraint or seclusion;
- (e) A summation of the consumer's mental status at the time of the face-to-face evaluation by the physician; and
- (f) How the consumer was informed of the behavioral criteria for discontinuation of restraints or seclusion.

506.11 The criterion for release of a consumer from restraints or seclusion is that the consumer no longer presents an imminent risk of serious injury to self or others, rather than that a period of time has passed.

507 SPECIFIC PROCEDURES FOR THE USE OF SECLUSION

507.1 When secluding a consumer, the following procedures shall be observed:

- (a) All potentially dangerous articles shall be removed from the consumer's person and the seclusion area;
- (b) If unclothed, the consumer shall be offered clothing at the earliest possible time;
- (c) The consumer shall not be placed in any room or environment where there are potentially hazardous conditions, such as electrical outlets, frayed wires, high temperatures, high humidity, or light fixtures in disrepair; and
- (d) The consumer shall be continually monitored as described in §§508.3 and 508.4 of this chapter, and the physical, mental, and emotional needs of the consumer shall be given prompt attention at all times.

507.2 If the MH provider secludes a consumer under the age of eighteen (18) the consumer shall be continuously monitored, face-to-face, by trained staff who shall be at the doorway window of the seclusion room for the duration of the seclusion event.

508 MONITORING THE USE OF FOUR-POINT AND FIVE-POINT RESTRAINT OR SECLUSION

508.1 Within one (1) hour after initiation of the use of restraint or seclusion and following the discontinuation of any restraints or seclusion of a consumer pursuant to this chapter, the physician or physician assistant shall conduct a face-to-face assessment of the physical, behavioral, mental, and emotional status of the consumer, including without limitation:

- (a) The consumer's physical, mental, and emotional state;

- (b) The consumer's behavior;
- (c) The appropriateness and effectiveness of the restraints or seclusion employed;
- (d) Any complications resulting from the use of the restraint or seclusion; and
- (e) Any medications ordered and the reasons for their use.

508.2 Such examination shall be documented in the consumer's clinical record, including the date and time of the examination, the name of the individual making the examination, and the findings of the examination.

508.3 In addition to an assessment by the consumer's physician or physician assistant, a trained and competent staff person shall, in person, continuously monitor and observe and regularly assess the consumer throughout the restraint or seclusion.

This monitoring and assessment shall be documented and shall include at a minimum:

- (a) Fifteen (15) minute assessments for signs of injury or medical distress;
- (b) Hourly assessments of nutrition and hydration needs;
- (c) Fifteen (15) minute assessments for circulation and hourly opportunities for range of motion in extremities;
- (d) Elicitation of vital signs at implementation of restraints or seclusion, with vital sign checks every fifteen (15) minutes for the first thirty (30) minutes, and if stable, then hourly and then again upon release from restraints. If unable to elicit vital signs at any time, the staff shall document efforts to obtain vital signs and the reasons it could not be done;
- (e) Hourly assessments of hygiene and elimination needs;
- (f) Fifteen (15) minute assessments of mental health status; and
- (g) Minimally, fifteen (15) minute assessments for readiness for discontinuation of restraints or seclusion.

508.4 Remote observation of a consumer via video camera or other device or technique is not permissible to meet the requirements of §508.3.

508.5 The consumer shall be released from restraints and seclusion when there is an assessed stabilization of behavioral status such that the consumer no longer presents an imminent risk of serious injury to self or others, or when the order for restraints or seclusion expires and is not renewed, whichever is earlier.

- 508.6 Restraints and seclusion may be terminated upon authorization of an RN, a physician or a physician assistant, except in the case of an emergency, when any staff may remove a consumer from restraints or seclusion to administer emergency treatment, evacuate the consumer from a hazardous condition such as fire or flood, or if for any reason the restraint or seclusion is causing harm to the consumer's physical health or safety.
- 509 POST EVENT ANALYSIS OF THE USE OF FOUR-POINT AND FIVE-POINT RESTRAINT OR SECLUSION**
- 509.1 All staff involved in the use of restraint or seclusion shall, within twenty-four (24) hours of the application of restraint or seclusion, conduct a post event analysis among themselves regarding the events surrounding the emergency that required the use of restraints or seclusion. The post event analysis is separate from the more formal treatment team debriefing described in §510 that is conducted by the consumer's team.
- 509.2 The MH provider's nursing supervisor, the nursing supervisor's designee or risk manager shall chair the post event analysis meeting. The post event analysis shall, at a minimum, include a discussion of:
- (a) The emergency that required the use of restraints or placement in seclusion, including a discussion of the precipitating factors that led up to the use of restraint or placement in seclusion;
 - (b) Alternative techniques that might have prevented the use of the restraint or seclusion;
 - (c) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraints or seclusion; and
 - (d) The outcome of the intervention, including any injuries that may have resulted from the use of restraints or seclusion.
- 509.3 Issues, concerns, and recommendations from the post event analysis meeting, shall be documented, by the person chairing the meeting, in a manner consistent with standard peer review and continuous quality improvement practices.
- 510 TREATMENT TEAM DEBRIEFING MEETING REGARDING THE USE OF FOUR-POINT AND FIVE POINT RESTRAINTS OR SECLUSION**
- 510.1 The consumer's treatment team shall conduct a treatment team debriefing following each incident of restraint or seclusion. If use of restraint or seclusion occurred at a site-based mental health crisis emergency program certified by DMH or at a DMH-contracted psychiatric crisis stabilization program, the treatment team members shall be deemed to include a representative from the consumer's assigned core service agency and the consumer's ACT team, if the consumer is currently authorized to receive ACT services.

- 510.2 The treatment team debriefing is a face-to-face meeting, which shall include treatment team members, the consumer, and the consumer's family members or personal representatives if the consumer so consents and they are available.
- 510.3 The treatment team debriefing shall include discussions about the causes giving rise to the emergency requiring the use of restraint or seclusion and how this information can be used to prevent future occurrences.
- 510.4 The treatment team debriefing meeting shall be initiated by the consumer's treatment team within twenty-four (24) hours following each incident of restraint or seclusion, or within the next business day in the case of weekends and holidays. The treatment team debriefing shall result in the following outcomes:
- (a) Assisting the consumer and staff in understanding the precipitants which may have evoked the behaviors necessitating the use of restraints or seclusion;
 - (b) Assisting the consumer in developing appropriate coping mechanisms or alternative behaviors that could be effectively utilized should similar situations, emotions, or thoughts present again;
 - (c) Assisting the staff in developing appropriate alternatives to the use of restraints or seclusion; and
 - (d) Developing and documenting, for inclusion in the service plan, a specific plan of interventions designed to avoid the future need for the use of restraints or seclusion.
- 510.5 MH provider staff shall document, in the consumer's clinical record, the time and place of the treatment team debriefing, the names of all individuals participating in the treatment team debriefing, the names of the MH provider staff excused from the treatment team debriefing and the reason for their absence, and any changes to the consumer's service plan that result from the debriefing.
- 510.6 The consumer shall be offered and provided any needed or desired counseling or treatment for any trauma that may have resulted from the use of restraints or seclusion.
- 510.7 MH provider staff shall notify the chief clinical officer or medical director for the MH provider each time restraints or seclusion for a consumer are used for a period of more than twelve (12) hours or when two (2) or more separate orders for restraints or seclusion of a consumer are given within twelve (12) hours of each other.
- 511 PHYSICAL HOLDS**
- 511.1 A physical hold is the application of physical force by a trained or qualified staff person without the use of any mechanical device, for the purpose of restraining

free movement of a consumer's body. A physical hold does not include briefly holding without due force a consumer in order to calm or comfort him or her, or holding a consumer's hand to safely escort him or her from one area to another.

- 511.2 A trained or qualified staff person may use physical holds, without a physician's order, for up to fifteen (15) minutes in an emergency where physical violence against self, another person, or property is occurring. A physical hold is used solely for the purpose of preventing harm to the consumer, the staff person, others or property.
- 511.3 The attending or treating physician shall order any use of a physical hold that will last longer than fifteen (15) minutes.
- 511.4 A second trained or qualified staff person shall be assigned to observe the consumer during the use of a physical hold.
- 511.5 For any use of a physical hold longer than fifteen (15) minutes, the procedures set forth in §§506.3, 506.6, 506.7, 506.8, 506.9, 506.10, and 506.11 of this chapter shall be followed.
- 511.6 Any order for a physical hold shall not exceed a total of one (1) hour.
- 511.7 The MH provider shall conduct a post event analysis and a treatment team debriefing in accordance with the requirements of §§509 and 510, respectively, for any use of a physical hold longer than fifteen (15) minutes.

512 MEDICAL RESTRAINTS

- 512.1 Medical restraints may be used to administer medical or surgical treatment to an uncooperative consumer, if:
- (a) In the written opinion of a physician licensed to practice medicine in the District, medical or surgical treatment is necessary to prevent the immediate serious injury or death of the consumer; and
 - (b) The procedures set forth in §§ 506.3, 506.9, 506.10 and §§508.1, and 508.2, governing the use of restraints, are followed.
- 512.2 The MH provider shall document in the consumer's clinical record that all attempts to gain the consumer's cooperation through less restrictive means have failed, or that making such attempts would delay the necessary emergency treatment and further jeopardize the consumer's life and safety.
- 512.3 The documentation in the consumer's clinical record shall also describe the circumstances that give rise to the medical emergency, as well as the reasons why restraints are deemed necessary to administer the needed treatment.

512.4 In the event the consumer is a minor or an adult with a legal guardian, the parent or guardian's consent shall be obtained if possible. If the parent or guardian is not available, the MH provider shall document all attempts to gain the parent's or guardian's consent, or that making such attempts would delay the necessary emergency treatment and further jeopardize the consumer's life and safety.

512.5 The least restrictive and most comfortable restraints available shall be used as necessary to accomplish the emergency medical or surgical procedure. The restraints may only be applied for the duration of the procedure and then shall be removed.

512.6 The use of restraints to perform routine medical procedures, such as phlebotomy, urine screen, or x-ray is prohibited, unless informed consent to the restraint is obtained from the consumer or the consumer's surrogate healthcare decision-maker pursuant to 22A DCMR, Chapter 1. The consent shall be in writing and placed into the consumer's clinical record for each procedure.

513 LEGALLY MANDATED RESTRAINTS

513.1 This chapter does not govern the use of legally mandated restraints. Legally mandated restraints are restraints ordered by a court of law or restraints that are applied, monitored, and removed at the discretion of a law enforcement officer, such as a Deputy United States Marshal, an agent of the Secret Service, or an officer of the Metropolitan Police Department, with custody of a consumer, or restraints applied by hospital staff to a maximum security consumer when being transported outside the facility, in accordance with forensic services policy approved by the chief clinical officer of DMH.

513.2 Metal handcuffs and anklets are prohibited, except with maximum security consumers, who are secured by forensic services personnel in accordance with forensic services policy approved by the chief clinical officer of DMH, or the order of a judge, U.S. Marshall or other law enforcement agency with appropriate jurisdiction for transport to:

- (a) The District of Columbia Superior Court or District Court of Appeals;
- (b) Any Federal Court;
- (c) Any facility outside of the hospital's forensic services facility, including, but not limited to facilities outside the hospital grounds.

513.3 All procedures required for application of emergency restraint, which are set forth in this chapter shall be followed, unless specifically superseded by court order or the policy of the law enforcement agency with custody of the consumer.

514 DRUG(S) USED AS A RESTRAINT

- 514.1 Only a physician licensed to practice medicine in the District may order a drug(s) to be used as a restraint.
- 514.2 A drug(s) used as a restraint is permitted only in an emergency when the consumer presents an imminent risk of serious injury to self or others and when alternative techniques are determined to be ineffective to prevent serious injury to the consumer or others.
- 514.3 The use of drugs to control extreme behavior shall not be administered with the intention of immobilizing the consumer's movements or rendering unconscious.
- 514.4 The physician ordering a drug(s) to be used as a restraint shall conduct a face-to-face assessment of the consumer within one hour of administration of the medication.
- 514.5 Each verbal or written order for a drug(s) to be used as a restraint shall state:
- (a) The name of the physician giving the order;
 - (b) The date and time the written order was given;
 - (c) The specific medication and dosage to be administered;
 - (d) The target symptom or behavior for which the drug is ordered;
 - (e) Any special instructions needed due to the consumer's medical condition, physical disability or history of abuse; and
 - (f) If required, the need for monitoring of specific medical conditions or more frequent monitoring of vital signs.
- 514.6 For each order, the physician, physician assistant or RN shall also document in the consumer's clinical record, a note separate from the order, which shall include:
- (a) Any less restrictive techniques, such as behavioral interventions or non-physical interventions used, attempted, or considered prior to ordering the drug;
 - (b) Whether there are any pre-existing medical conditions or any physical disabilities that would place the consumer at potentially greater risk due to the use of the drug; and
 - (c) The basis, including a description of the consumer's behavior and the circumstances leading to the use of the drug.

- 514.7 A trained competent staff person shall regularly assess the consumer for the first two hours after the drug is administered. This assessment shall be documented and include:
- (a) Assessments for signs of injury or medical distress shall be done every fifteen (15) minutes; and
 - (b) Elicitation of vital signs upon administering the drug with checks every fifteen (15) minutes. If unable to elicit vital signs at any time, the staff shall document efforts to obtain vital signs and the reasons it could not be done.

515 USE OF RESTRAINTS OR SECLUSION WITH SPECIAL POPULATIONS

- 515.1 Consideration should be given to removing dentures or other dental devices either prior to the use of restraints or seclusion, or at the earliest opportunity after initiation of restraints or seclusion.
- 515.2 Only soft restraints may be used with frail consumers. Leather restraints should never be used with frail consumers as these may cause lesions or fractures, especially in cases of osteoporosis.
- 515.3 Consumers affected by mental retardation or developmental disability who become agitated or violent should be carefully assessed for an underlying medical condition that may be causing the behavioral change.

- 515.4 Children and youth residing in inpatient hospital settings or residential treatment centers shall receive an assessment to identify those who have experienced physical, psychological, or sexual trauma, including abuse, and those at high risk for seclusion and restraint events for any reason. The assessment shall include a review of the child or youth's medical condition and any disability.
- 515.5 The assessment referenced in §515.4 shall be completed within twenty-four (24) hours of admission.
- 515.6 With the exception of physical holds as defined in this chapter, the use of restraint or seclusion with children or youth who have been sexually or physically abused within the past two years is strictly prohibited.
- 515.7 For children and youth residing in hospitals or RTCs, initial service plans shall include positive interventions to avoid the use of seclusion and restraints, especially for children most likely to lose self-control.
- 515.8 For consumers who are deaf or unable to speak, any use of restraint or seclusion must include constant one-to-one observation. Efforts to communicate with the person using sign language or in writing, must be made and documented in the clinical record.
- 516 INJURY OR DEATH AS A RESULT OF RESTRAINT OR SECLUSION**
- 516.1 If a consumer is injured during the process of being placed in restraints or seclusion or while in restraints or seclusion, MH provider staff shall:
- (a) Immediately obtain medical treatment from qualified medical personnel for the consumer;
 - (b) Document in the consumer's clinical records the injuries and any treatment provided for these injuries;
 - (c) Complete and submit a major unusual incident report to the DMH Office of Accountability; and
 - (d) Document in the consumer's record and submit a major unusual incident report to document any injuries to staff resulting from the use of restraints or seclusion during an emergency.
- 516.2 Any death that occurs while a consumer is in the process of being restrained or secluded, while the consumer is in restraints or seclusion, or any death that could reasonably have been the result of the use of restraint or seclusion shall be:
- (a) Documented in the consumer's clinical record;
 - (b) Reported immediately (but no later than one (1) hour after discovery of the death) to the DMH Office of Accountability; and

- (c) Reported to any other federal or District agencies as required by federal and District laws and regulations.

516.3 Staff involved in applying restraints or seclusion to abate an emergency that results in injury to the consumer or staff shall meet with supervisory staff to evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. The meeting and evaluation of the circumstances that caused the injury and development of a plan to prevent future injuries may occur in conjunction with either the post event analysis described in §509 or the treatment team debriefing described in §510.

517 PROTECTIVE MEASURES

517.1 Protective measures involve the use of gerichairs, chairs with trays, bed rails, straps, mitts or other devices which restrict freedom of movement or access to one's body in order to prevent falls, maintain posture and for other medical purposes.

517.2 All MH providers may use protective measures in accordance with the requirements of this chapter.

517.3 Protective measures shall be used only as a last resort when other adaptive or assistive devices, physical therapy, or environmental changes are inadequate to prevent injury to the consumer.

517.4 The application of any protective measure that involves a physical restraint (a device, material, or apparatus that the consumer cannot easily remove) may only be applied in accordance with the procedures set forth in §§ 506.1 – 506.11 and §508 of this chapter. All other protective measures may be applied pursuant to the procedures set forth in this section.

517.5 A RN may initiate the use of protective measures but shall obtain a verbal order from a physician or physician assistant, within one (1) hour of initiating protective measures. The initiation of protective measures shall be based on a documented assessment of the consumer's history and condition that indicates the strong probability that substantial harm to the consumer will occur in the absence of such measures.

517.6 If the consumer is a minor or an adult who has a legal guardian, the MH provider staff shall notify the parent(s) or legal guardian(s) that the consumer has been placed in protective measures promptly after the initiation of these measures.

517.7 Use of protective measures requires a written time limited order by the attending or treating physician. An order for protective measures may be written for up to twenty-four (24) hours.

517.8 Scheduled observations for consumers in protective measures shall be made every fifteen (15) minutes and documented in the consumer's clinical record.

- 517.9 Trained nursing staff shall periodically assess any consumer in protective measures. The protective measures shall be discontinued as soon as alternative measures for safety are feasible.
- 517.10 Physical needs of consumers in protective measures shall be promptly met. The consumer's physical condition shall be assessed, and the opportunity for personal care, including fluids, bathroom use, range of motion, meals, and hygiene shall be provided and documented throughout the use of the protective measures. The consumer shall be monitored and assisted by:
- (a) Recording the consumer's physical condition every fifteen (15) minutes;
 - (b) Assessing for safety, circulation and comfort every fifteen (15) minutes;
 - (c) Providing an opportunity for hourly access to the bathroom (or more often as appropriate) while the consumer is awake;
 - (d) Providing an opportunity for regular meals with any needed special precautions taken;
 - (e) Providing an opportunity for fluids at least every one (1) hour while the consumer is awake, with fluid type and amount recorded when consumed;
 - (f) Providing an opportunity for range of motion of extremities every two (2) hours while the consumer is awake; and
 - (g) Providing an opportunity for a bath or shower at least once each twenty-four (24) hours or more often when necessary.
- 517.11 A service plan update is required for any consumer in protective measures in excess of twenty-four (24) hours. The service plan shall address the use of alternative interventions to reduce the need for protective measures.
- 517.12 All protective devices shall be sanitized after each use.
- 517.13 Protective devices shall only be used in a manner consistent with the manufacturers instructions for case and use of the devices.
- 518 NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN(S) OF USE OR CONTINUATION OF RESTRAINTS OR SECLUSION**
- 518.1 If the consumer is a minor or an adult with a legal guardian, the MH provider staff shall notify the parent(s) or legal guardian(s) of the consumer who has been restrained or secluded within two hours of the initiation or continuation of any restraints or seclusion.
- 518.2 The MH provider staff shall document in the consumer's clinical record that the parent(s) or legal guardian(s) were notified of the use of the restraints, including

the date and time of notification and the name of the MH provider staff member providing the notification.

518.3 In the event the parent(s) or legal guardian(s) cannot be located, diligent effort to contact them shall be documented.

519 MH PROVIDER POLICIES AND PROCEDURES

519.1 Each MH provider shall establish, maintain, and adhere to written policies and procedures regarding the use of restraints and seclusion for consumers that comply with applicable federal and District laws and regulations. A MH provider that is not specifically authorized to use restraint and seclusion pursuant to §§500.7 shall establish a policy strictly prohibiting the use of restraints and seclusion at any time, although the policy shall also require reporting of the use of restraint or seclusion and staff training.

519.2 The written policies and procedures for the MH providers identified in §500.7 shall describe the following:

- (a) How respect for consumers and their families will be maintained prior to, during, and after the utilization of any method of restraint or seclusion;
- (b) The use of a consumer's advance instructions regarding treatment preferences in the event of a psychiatric emergency and how those treatment preferences will be honored.
- (c) The process or opportunity for a consumer who is in restraints or seclusion to maintain personal care, participate in personal care processes, engage in normal bodily functioning (including access to toilets), receive nourishment and fluids, exercise limbs, have a systematic release of restrained limbs, and receive other necessary care during and immediately after the utilization of any restraints or seclusion;
- (d) The process for ensuring and monitoring the safety and hygiene of a consumer who is in restraints or seclusion;
- (e) The DMH-approved policy for face-to-face monitoring required by §505.2 for MH providers using restraints and seclusion simultaneously;
- (f) The process for monitoring the space used for restraint or seclusion to ensure a comfortable room temperature and necessary light at all times;
- (g) How the physical, mental, and emotional well being of the consumer will be promoted and maintained at all times during the use of restraint and seclusion;

- (h) How the consumer's modesty, appropriate visibility to others, and comfortable body temperature will be maintained and monitored at all times during the use of restraint and seclusion;
- (i) Which staff are responsible for examining and monitoring the consumer prior to, during, and after the utilization of any method of restraint or seclusion;
- (j) Which staff have authority to order the initiation of and discontinuation of restraints and seclusion;
- (k) What techniques staff should use prior to using restraints or seclusion;
- (l) What assistance shall be provided to a consumer who has been placed in restraints or seclusion to assist the consumer in meeting the criteria for discontinuation of the restraints or seclusion, which staff are responsible for providing this assistance, and documentation requirements;
- (m) Which staff are responsible for reporting any injuries or death of a consumer being placed in or while in restraints or seclusion;
- (n) The training requirements for all staff that have direct contact with consumers as required by these rules;
- (o) The process for debriefing the consumer and the consumer's family, if appropriate, and MH provider staff following the use of any restraint or seclusion;
- (p) The process for reviewing compliance with the MH provider's restraint and seclusion policy by all MH provider staff;
- (q) The process for complying with reporting requirements and other external mandates regarding the use of restraints or seclusion on consumers; and
- (r) Information on how a consumer may contact the District's Protection and Advocacy program, including the name of the program and its address and phone number.

519.3 MH providers shall include consumers and families in formulating the MH provider's restraint and seclusion policy.

519.4 Each MH provider shall ensure that all MH provider staff, including administrative, clerical, and support staff, comply with the MH provider's restraint and seclusion policy.

520 MH PROVIDER REPORTING REQUIREMENTS

005980

- 520.1 Each MH provider shall provide certification of its compliance with this chapter to DMH within thirty (30) days of the effective date of this chapter and annually thereafter. The MH provider shall prepare its initial and annual certification of compliance with this chapter using a format approved by DMH.
- 520.2 If a MH provider has provided a written attestation of its compliance with federal rules and regulations governing the use of restraints and seclusion to the District's Medicaid Administration Agency (MAA), the MH provider shall also provide DMH with a copy of the MAA attestation.
- 520.3 Each MH provider shall report the death of a consumer or other serious injury that may have reasonably resulted from the use of restraint or seclusion to DMH in accordance with DMH's unusual incident reporting policy as set forth in §516.1 and 516.2, and applicable federal and District laws and regulations.
- 520.4. Each use of restraint or seclusion shall be reported to the MH provider's quality improvement committee for review, discussion, trend analysis and any recommendations for programmatic or treatment changes.
- 520.5 The DMH Deputy Director for Accountability may require an external review of a MH provider's use of seclusion and restraint based on increasing or excessive utilization patterns, injuries to staff or consumers, or deviations from this policy.
- 520.6 The MH provider shall also comply with any reporting requirements deemed necessary by DMH.

521 STAFF EDUCATION AND TRAINING

- 521.1 Each MH provider identified in §500.7 shall design and implement a training and education program for all MH provider staff aimed at minimizing the use of restraint and seclusion and maximizing safety for consumers and MH provider staff when restraint or seclusion are used.
- 521.2 Each MH provider shall require all staff members to receive effective, ongoing, competency-based education and training on the following:
- (a) Understanding and appropriately responding to underlying behaviors of consumers that precipitate the use of restraints or seclusion;
 - (b) Techniques to identify staff interactions, consumer medical conditions, and environmental factors that may trigger consumer behavior resulting in the use of restraints or seclusion;
 - (c) The use of de-escalation and other non-physical behavior management techniques, such as mediation, conflict resolution, active listening, and verbal and observational methods, to reduce or eliminate the use of restraints and seclusion;

- (d) The safe use of restraints and seclusion, including the ability to recognize and respond to signs and symptoms of physical, mental, medical or emotional distress, or impairments or injury in consumers who are restrained or secluded; and
- (e) Cardiopulmonary resuscitation (CPR), including certification and periodic re-certification in CPR.

521.3 Each MH provider identified in §500.7 shall require all staff members who are authorized to physically apply restraints or seclusion to receive ongoing training and demonstrate competence in the safe use of restraints and seclusion, including:

- (a) Acceptable techniques for physically holding a consumer;
- (b) Acceptable take-down procedures; and
- (c) Acceptable means for applying and removing all types of restraints used, including protective measures.

521.4 Each MH provider identified in §500.7 shall require all staff members who are authorized to perform fifteen (15) minute assessments of consumers in restraints or seclusion to receive ongoing training and demonstrate competence in:

- (a) Taking vital signs and interpreting their relevance;
- (b) Recognizing nutritional and hydration needs;
- (c) Checking circulation and range of motion in extremities;
- (d) Addressing hygiene and elimination needs;
- (e) Addressing physical and psychological status and comfort;
- (f) Assisting consumers in meeting behavioral criteria for the discontinuation of restraints or seclusion; and
- (g) Recognizing when to contact a physician or emergency medical services to evaluate or treat a consumer's physical condition.

521.5 Each MH provider identified in §500.7 shall require all staff members who are authorized to initiate the use of restraints or seclusion, or to perform evaluations of consumers who are in restraints or seclusion to receive education about and demonstrate competence in:

- (a) Recognizing how age, developmental considerations, gender issues, cultural issues, ethnicity, traumatology, and history of sexual or physical abuse may affect the way in which a consumer reacts to physical contact; and

- (b) The use of behavioral criteria for the discontinuation of restraints or seclusion and how to assist a consumer in meeting the criteria.

- 521.6 All staff employed by MH providers shall demonstrate their competencies, as specified in this section, on an annual basis.
- 521.7 Each MH provider shall ensure adequate levels of staffing and appropriate staffing configurations at all times, based on factors such as the physical environment, consumer diagnosis and needs, co-occurring conditions, acuity levels, and the age or developmental status of each consumer.
- 521.8 Each MH provider shall include an annual evaluation of the factors set forth in §521.2 in its staff performance evaluation or quality improvement program.
- 521.9 Each MH provider shall document in the staff personnel records that necessary training, education and competency have been successfully completed. Documentation shall include the date training was completed, the type of training completed, and the name of the individual certifying the completion of training.
- 521.10 All training programs and materials used by each MH provider shall be made available, upon written request, for review by DMH.

522 VIOLATIONS OF THIS CHAPTER

- 522.1 If the consumer or any third party believes that the consumer's rights with respect to the use of restraints or seclusion have been violated for any reason, such consumer or third party may file a grievance in accordance with the procedures prescribed in 22A DCMR, Chapter 3.
- 522.2 Violations of this chapter may subject the MH provider to sanctions to be determined by DMH. Sanctions may include reporting to the Center for Medicare and Medicaid Services and/or suspension or revocation of the MH provider's licensure or certification, depending on the nature of the violation.

599 DEFINITIONS

"Assertive community treatment or "ACT" -- intensive, integrated rehabilitative, crisis, treatment, and community support provided to adult consumers with serious and persistent mental illness by an interdisciplinary team, in accordance with the requirements of 22 DCMR Chapter 34.

"Assertive Community Treatment team" or "ACT team" - the mobile interdisciplinary team of qualified practitioners and other staff involved in providing ACT to a consumer.

"Attending physician" -- the physician on duty or on call at the MH provider at the time an emergency requiring the use of restraints/seclusion occurs. In some instances, the attending physician may also be the consumer's treating physician.

“Cardiopulmonary resuscitation” – an emergency technique to revive somebody whose heart has stopped beating that involves clearing the person’s airways and then alternating heart compression with mouth-to-mouth respiration.

“Consumer” -- an adult, child, or youth who seeks or receives mental health services or mental health supports in the District of Columbia under Chapter 5 of Title 21 of the District of Columbia Code, or Chapter 5 of Title 24 of the District of Columbia Code, regardless of whether the person’s status is voluntary, non-protesting, or involuntary.

“Consumer statement of treatment preferences” – a document or form completed by a consumer in accordance with District of Columbia Official Code §7-1231.01 that indicates the consumer’s preferences regarding the use of seclusion or restraints and less restrictive alternatives to be used or attempted in a psychiatric emergency situation. A consumer statement of treatment preferences may be contained in either a Declaration of Advance Instructions or Durable Power of Attorney for Healthcare.

“Core services agency” - a DMH-certified community-based provider of mental health rehabilitation services that has entered into a Human Care Agreement with DMH to provide specified services and serves as the clinical home for consumers enrolled in and eligible to receive mental health rehabilitation services.

“DMH” -- the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental Health Services.

“Emergency” – a situation in which a consumer is experiencing a mental health crisis and is presenting an imminent risk of serious injury to self or others.

“Forensic services” – the program operated by DMH at Saint Elizabeths Hospital that provides court-ordered and legally mandated mental health services to persons who are involved in the criminal justice system and require inpatient pretrial examination and treatment; inpatient hospitalization and treatment due to a verdict of not guilty by reason of insanity and inpatient hospitalization while serving a prison sentence.

“Inpatient mental health service” -- residence and treatment provided in a psychiatric hospital or unit, which is licensed or operated by the Mayor.

“Maximum security consumers” – those persons who have been committed to either DMH or Saint Elizabeths Hospital by the Criminal Division of the local or federal courts or the Department of Corrections and who reside on a maximum security unit within the forensic services program.

“Mayor” – means the Mayor of the District of Columbia or any executive branch agency the Mayor may designate for purposes of this chapter.

“Mental health provider” or “MH Provider” -- any entity that is (1) operated, licensed, or certified by the Mayor to provide mental health services or mental health supports; or (2) that has entered into an agreement with the Mayor to provide mental health services or mental health supports.

“Physical hold” -- the application of physical force without the use of any mechanical device, for the purpose of restraining the free movement of a consumer’s body.

“Physician” -- a person licensed under the laws of the District of Columbia to practice medicine, or a person who practices medicine in the employment of the government of the United States.

“Physician assistant” -- a health professional who meets the qualifications for licensure as a physician assistant by the District of Columbia Board of Medicine and who is licensed in the District of Columbia as a physician assistant, or a person who practices as a physician assistant in the employment of the government of the United States.

“Registered nurse” or “RN” -- a person licensed as a registered nurse in accordance with applicable District of Columbia laws and regulations or a person who practices nursing in the employment of the government of the United States.

“Restraints” -- a physical restraint or a drug that is used for the purpose of restraint. Restraints do not include a physical hold of fifteen (15) minutes or less in duration.

“Seclusion” -- any confinement of a consumer alone in a room or an area which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will.

“Serious injury” -- any significant impairment of the physical or mental condition of a person, as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else, as well as emotional trauma requiring specific services and supports in addition to or beyond those mental health services and supports already being received by the person.

“Service plan” -- the individualized recovery plan for adults or the individualized plan of care for children/youth, which includes the consumer’s treatment goals, strengths, challenges, objectives, and interventions.

“Site-based crisis emergency provider” -- an MH provider certified by DMH to provide crisis emergency services in accordance with 22 DCMR 3419 and provides crisis emergency services pursuant to the terms of a human care agreement with DMH. The modifier, “site-based” refers specifically to those services provided in the physical facility of the crisis emergency provider (in

contrast to its community-based, outreach services). A site-based crisis emergency provider must have the ability to provide psychiatric emergency treatment including the continuous availability of an on-site or on-call psychiatrist, the continuous availability of a formulary of psychotropic medications, nursing staff continually available to give emergency orders for the use of restraints and the appropriate equipment.

“Staff” -- those individuals with responsibility for managing a person's health care or participating in an emergency and who are employed by the MH provider on a full-time, part-time, or contract basis, including without limitation physicians, nurses, orderlies, resident physicians, interns, and direct care workers.

“Treating physician” – the physician, who may be a psychiatrist, responsible for the regular and ongoing mental health treatment of the consumer. In some instances, the consumer’s treating physician may also be the attending physician.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty (30) days after the date of publication of this notice in the Register. Comments should be filed with Anne M. Sturtz, General Counsel, Department of Mental Health, 64 New York Ave, N.E., Fourth Floor, Washington, D.C. 20002 or anne.sturtz@dc.gov. Additional copies of these rules are available from the Office of the General Counsel, Department of Mental Health.