

DISTRICT OF COLUMBIA BOARD OF EDUCATION

NOTICE OF FINAL RULEMAKING

ERRATA

The Board of Education ("Board") published, in the D.C. Register at 50 DCR 8806, October 17, 2003, a Notice of Final Rulemaking amending Section 104.10, and adding Section 104.11, Chapter 1, Bylaws of the Board of Education of Title 5 of the District of Columbia Municipal Regulations.

The substance of the rulemaking notice was adopted by the Board on August 1, 2003. However, the rulemaking notice contained typographical errors. The corrected text is set forth below.

104 DUTIES OF THE OFFICERS OF THE BOARD

- 104.1 The President shall preside at the meetings of the Board of Education and the Committee of the Whole. The President may participate in the discussions on matters before the Board, and vote on any action taken by the Board at monthly meetings, special or emergency meetings, and meetings of the Committee of the Whole.
- 104.2 The President shall appoint the chairperson and membership of all standing committees and ad hoc committees established by the Board. The President may for good cause remove a committee chairperson or member unless overridden by a two-thirds (2/3) majority vote of the Board at the next regular meeting of the Board.
- 104.3 Whenever a committee vacancy occurs, the President shall promptly appoint a new committee member. In making the appointment, the President shall give special consideration to newly elected Board members.
- 104.4 The President shall not serve as chairperson of any committee except the Committee of the Whole, but shall be a member *ex officio* with the right to vote of each standing and ad hoc committee.
- 104.5 The President shall act as official spokesperson for the Board when the Board is not in session, however, the President shall only represent the position of the Board of Education as established by the official acts of the Board. The President shall perform other duties as may be authorized by this chapter, the Board, or by the laws of the District of Columbia.
- 104.6 The Vice President shall assume the duties, responsibilities and privileges of the President in the absence or at the request of the President.
- 104.7 The Secretary shall supervise record keeping, execute such documents permitted by law, have custody of the books of record of Board proceedings, and perform such other duties as the law requires and the Board assigns.
- 104.8 The Treasurer shall assume such fiscal monitoring responsibilities as determined by a majority vote of the Board.
- 104.9 In the absence of both the President and the Vice-President, the Secretary shall serve as the President *pro tempore* and perform all the duties of the President.
- 104.10 The Board shall appoint an Executive ~~Secretary~~ **Director** to act as custodian of the records of the Board, certify and maintain the proceedings of the Board, and conduct and supervise the daily business of the Office of the Board, which includes its activities as State Education Agency, chartering authority and policy-maker for the public schools of the District of Columbia. The Executive ~~Secretary~~ **Director** shall prepare a record of Board proceedings as required by law or this chapter; ~~an~~ **and** shall perform all other duties authorized by law, this chapter, or official acts of the Board, or as assigned by the Board.
- 104.11 The Board shall appoint a Director of the Office of Charter School Oversight, who shall serve at the pleasure of the Board. 7223

**THE DISTRICT OF COLUMBIA
LOTTERY AND CHARITABLE GAMES CONTROL BOARD
NOTICE OF PROPOSED RULEMAKING**

The Executive Director of the District of Columbia Lottery and Charitable Games Control Board, pursuant to the authority set forth in D.C. Official Code §3-1306, District of Columbia Financial Responsibility and Management Assistance Authority Order issued September 21, 1996, and Office of the Chief Financial Officer Financial Management Control Order No. 96-22 issued November 18, 1996, hereby gives notice of the adoption of amendments to Chapters 6 and 9 of Title 30 DCMR, "Lottery and Charitable Games." These final rules are necessary to implement changes to the POWERBALL® game in concert with the Multi-State Lottery Association ("MUSL") twenty-nine lottery organizations members on August 28, 2005. No substantive changes have been made to the text of these proposed rules published in the D.C. Register on June 17, 2005 at 52 DCR 5762. These final rules will be effective upon publication of this notice in the D.C. Register.

AMEND CHAPTER 6, "CLAIMS AND PRIZE PAYMENTS"

Amend section 606.3 to read as follows:

- 606.3 Except as otherwise provide in Chapter 9 of this title, annuitized prizes shall be paid annually in thirty (30) payments with the initial payment being made in cash or check, to be followed by twenty-nine (29) payments funded by the annuity. All annuitized prizes shall be paid annually in thirty (30) graduated payments (increasing each year) by a rate as determined by the Executive Director. Prize payments may be rounded down to the nearest one thousand dollars (\$1,000).

AMEND CHAPTER 9, "DESCRIPTION OF ONLINE GAMES"

Amend section 906 to read as follows:

906 DESCRIPTION OF THE POWERBALL® GAME

- 906.1 POWERBALL® is a five (5) out of fifty-five (55) plus one (1) out of forty-two (42) online lottery game which pays the Grand Prize, at the player's election, on an annuitized pari-mutuel basis or as a cash lump sum payment of the total cash held for this prize pool on a pari-mutuel basis. Except as provided in these rules, all other prizes are paid on a fixed cash basis. To play POWERBALL®, a player must select five (5) different numbers, between one (1) and fifty-five (55) and one additional number between one (1) and forty-two (42) for input into a terminal.

Amend section 908 to read as follows:

908 POWERBALL® GRAND PRIZE PAYMENT

Amend section 908.1 to read as follows:

908.1 Except as provided in section 908.19, POWERBALL® Grand prizes shall be paid with either a per winner annuity or cash payment. Annuitized prizes shall be paid in thirty (30) annual graduated installments over a period of twenty-nine (29) years.

Amend section 909 to read as follows:

909 POWERBALL® FIXED PRIZE STRUCTURE

909.1 Provided the prize pools are fully funded, the fixed prize payments for POWERBALL® based on a one dollar (1) bet are as follows:

Number of Matches Per Play

(a)	All five (5) of the first set and none of the second set	\$ 200,000.00
(b)	Any four (4) of the first set plus one (1) of the second set	\$ 10,000.00
(c)	Any four (4) of the first set and none of the second set	\$ 100.00
(d)	Any three (3) of the first set plus one (1) of the second set	\$ 100.00
(e)	Any three (3) of the first set and none of the second set	\$ 7.00
(f)	Any two (2) of the first set plus one (1) of the second set	\$ 7.00
(g)	Any one (1) of the first set plus one (1) of the second set	\$ 4.00
(h)	None of the first set plus one (1) of the second set	\$ 3.00

Amend section 910 to read as follows:

910 PROBABILITY OF WINNING

910.1 The following table sets forth the probability of winning and the probable distribution of winners in and among each prize category, based upon the total number of possible combinations in POWERBALL®

PROBABILITY DISTRIBUTION

<u>Number of Matches Per Ticket</u>	<u>Winners</u>	<u>Probability</u>	<u>Probable Set Prize Amount</u>
All five (5) of first set plus one (1) of the second set	1	1: 146,107,962.0000	Jackpot
All five (5) of the first set and none of the second set	41	1: 3,563,608.8293	\$200,000.00
Any four (4) of the first set plus one (1) of the second set	250	1: 584,431.8480	\$10,000.00
Any four (4) of the first set and none of the second set	10,250	1: 14,254.4353	\$100.00
Any three (3) of the first set plus one (1) of the second set	12,250	1: 11,927.1806	\$ 100.00
Any three (3) of the first set plus none of the second set	502,250	1: 290.9068	\$7.00
Any two (2) of the first set plus one (1) of the second set	196,000	1: 745.4488	\$7.00
Any one (1) of the first set plus one (1) of the second set	1,151,500	1: 126.8849	\$4.00
None of the first set plus one (1) of the second set	2,118,760	1: 68.9592	\$3.00
Overall	3,991,302	1: 36.6066	

Amend sections 913.3 and 913.4 to read as follows:

- 913.3 A qualifying play which wins one of the eight lump sum set prizes will be multiplied by the number selected (2 through 5), in a separate random Power Play drawing announced during the official POWERBALL® drawing.
- 913.4 A separate random Power Play drawing shall be conducted and results announced during each of the regular POWERBALL® drawings held during the promotion. During each POWERBALL® drawing a single number from a series of 15 numbers will be selected. The numbers available for selection are 2, 2, 2, 2, 3, 3, 3, 3, 4, 4, 4, 4, 5, 5, 5, 5. The Executive Director may change one or more of these multiplier numbers for special promotions from time to time.

Amend section 914 to read as follows:

914 POWERBALL® POWER PLAY PRIZE POOL AND PRIZE PAYMENT

- 914.1 The prize pool for all prize categories shall consist of up to forty-nine and three tenths percent (49.3%) of each drawing period's sales, including tax, after the POWERBALL® prize reserve accounts reach the amounts designated by the Executive Director in accordance with all agreements governing the conduct of POWERBALL® and Power Play. Once the prize reserve accounts exceed the designated amounts, the excess shall become part of the prize pool. Any amount remaining in the prize pool at the end of this game shall be carried forward to a replacement game prize reserve account or expended as otherwise directed by the Executive Director in accordance with all agreements governing the conduct of POWERBALL® and Power Play.
- 914.2 An additional one and one-half percent (1.5%) of sales, including tax, may be collected and placed in trust in one or more prize reserve accounts until the prize reserve accounts reach the amounts designated by the Executive Director in accordance with all agreements governing the conduct of POWERBALL® and Power Play.
- 914.3 Except as provided in these rules, all prizes awarded shall be paid as lump sum set prizes. Instead of the POWERBALL® set prize amounts, qualifying Power Play plays will pay the amounts shown below when matched with the Power Play number drawn:

POWERBALL® Pays Instead-----					
Prize Amount	5X	4X	3X	2X	
Match 5+0	\$200,000	\$1,000,000	\$800,000	\$600,000	\$400,000
Match 4+1	\$10,000	\$50,000	\$40,000	\$30,000	\$20,000
Match 4+0	\$100	\$500	\$400	\$300	\$200
Match 3+1	\$100	\$500	\$400	\$300	\$200
Match 3+0	\$7	\$35	\$28	\$21	\$14
Match 2+1	\$7	\$35	\$28	\$21	\$14
Match 1+1	\$4	\$20	\$16	\$12	\$8
Match 0+1	\$3	\$15	\$12	\$9	\$6

7227

In certain rare instances, the POWERBALL® set prize amount may be less than the amount shown. In such case, the Power Play prizes will be a multiple of the new POWERBALL® prize amount. For example, if the Match 5 POWERBALL® set prize amount of \$200,000 becomes \$25,050 under the rules of the POWERBALL® game, then a Power Play player winning that prize amount where a "5" has been drawn would win \$125,250 ($\$25,050 \times 5$).

- 914.4 The following table sets forth the probability of the various Power Play numbers being drawn during a single POWERBALL® drawing.

<u>Power Play</u>	<u>Probability of Prize Increase</u>
5X – Prize Won Times 5	1 in 4
4X – Prize Won Times 4	1 in 4
3X – Prize Won Times 3	1 in 4
2X – Prize Won Times 2	1 in 4

Power Play does not apply to the POWERBALL® Grand Prize or to any Bonus Prize.

- 914.5 The prize money allocated to the Match 5 Bonus Prize shall be divided equally by the number of games boards winning the Match 5 prize when a game board wins the new high jackpot amount.

**DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH**

NOTICE OF FINAL 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.

Final action to adopt these rules was taken on July 25, 2005. Notice of Emergency and Proposed Rulemaking was published on June 24, 2005 (52 D.C.R. 5957). 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. No comments were received on the rules published on June 24, 2005. There have been no substantive changes made to the proposed rules. These rules will be effective on the 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

DISTRICT OF COLUMBIA REGISTER

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**

- 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

ARTICLE 22A REGULATION

- (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.

THE DISTRICT OF COLUMBIA TAXICAB COMMISSION

ERRATA

The District of Columbia Taxicab Commission published a Notice of Final Rulemaking amending 31 DCMR Chapter 5 "Taxicab Companies, Associations and Fleets" at 52 DCR 6677 (July 15, 2005). The notice erroneously assigned the date of adoption as July 5, 2005, instead of June 7, 2005.

ZONING COMMISSION FOR THE DISTRICT OF COLUMBIA
NOTICE OF FINAL RULEMAKING
and
Z.C. ORDER NO. 04-28
Z.C. Case No. 04-28
(Text Amendments – 11 DCMR)
(Department of Motor Vehicles – Driver's License Road Test Facilities)
June 13, 2005

The Zoning Commission for the District of Columbia, pursuant to its authority under § 1 of the Zoning Act of 1938, approved June 20, 1938 (52 Stat. 797, as amended; D.C. Official Code § 6-641.01); having held a public hearing as required by § 3 of the Act (D.C. Official Code § 6-641.03); and having referred the proposed amendments to the National Capital Planning Commission for a 30-day period of review pursuant to § 492 of the District of Columbia Charter; hereby gives notice of the adoption of amendments to § 199 (Definitions), § 501 (Uses as a Matter of Right (SP)), § 601 (Uses as a Matter of Right (CR)), § 721 (Uses as a Matter of Right (C-2)), § 801 (Uses as a Matter of Right (C-M)), § 901 (Uses as a Matter of Right (W)), and Chapter 21 (Off-Street Parking Requirements) of the Zoning Regulations (Title 11 DCMR). The amendments will permit Driver's License Road Test Facilities as a matter of right within the Special Purpose, Mixed Use, Commercial (except C-1), Industrial (C-M and M) and Waterfront District (except in W-0 and W-1) zone districts. The Commission took final action to adopt the amendments at a public meeting held on June 13, 2005.

This final rulemaking is effective upon publication in the *D.C. Register*.

Existing Regulations

The existing regulations do not provide a use that adequately meets the needs of the District of Columbia Department of Motor Vehicles ("DMV") for its road testing facilities. Without these amendments, DMV would need to obtain variance relief to expand or establish new road testing facilities, except within the Central Area where District government uses are not subject to Zoning. This would inhibit DMV's plans to locate its facilities in appropriate and convenient locations the District.

Description of Text Amendment

The Commission initiated this rulemaking in response to a petition filed by the Office of Planning on behalf of DMV. The text amendment accommodates DMV Driver's License Road Test Facilities by defining a DMV Driver's License Road Test Facility as a "building and associated paved area used by the District of Columbia Department of Motor Vehicles in connection with road tests or other tests of driving ability given to applicants for drivers' licenses or endorsements," permitting such facilities as a distinct use in the zone districts described above, and establishing off-street parking requirements for the facilities.

Relationship to the Comprehensive Plan

The amendment is not inconsistent with the goals of the Comprehensive Plan and is consistent with the following sections of the Comprehensive Plan: § 102.3, which advocates improving public facilities in order to stabilize the District's neighborhoods; § 601 which recommends the District provide adequate and energy-efficient public facilities in good condition to support the cost-effective delivery of municipal programs and services; and § 606.1 which expresses the objective to locate public facilities to provide optimum service and to support the land use, transportation, economic and social development, and neighborhood improvement objectives.

Public Hearing and Proposed Action

The Commission held a public hearing on March 17, 2005, and took proposed action immediately thereafter to approve the advertised text, except the provision that would have permitted DMV Drivers' License Road Test Facilities in W-1 Zone Districts. The Commission felt that such facilities would not be compatible with that Zone District or with the goals of the Anacostia Waterfront Initiative. A Notice of Proposed Rulemaking was published in the *D.C. Register* on April 8, 2005 at 52 DCR 3649, for a 30-day notice and comment period. No comments were received.

The proposed rulemaking was also referred to the National Capital Planning Commission ("NCPC") pursuant to § 492 of the District of Columbia Charter. NCPC, by report dated April 28, 2005, found that the proposed text amendment would not adversely affect the federal interests nor be inconsistent with the Federal Elements of the Comprehensive Plan.

The Office of the Attorney General determined that this rulemaking meets its standards of legal sufficiency.

Final Action

The Commission took final action to adopt the rulemaking at its regularly scheduled public meeting on June 13, 2005. No substantive changes were made to the advertised prepared text.

Based on the above, the Commission finds that the proposed amendments to the Zoning Regulations are in the best interests of the District of Columbia, consistent with the purpose of

the Zoning Regulations and Zoning Act, and not inconsistent with the Comprehensive Plan for the National Capital.

In consideration of the reasons set forth herein, the Zoning Commission hereby **APPROVES** the following amendments to chapters 1, 5, 6, 7, 8, 9 and 21 of the Zoning Regulations, Title 11 DCMR. Added wording is in **bold** and underlined, and deleted wording is shown in ~~strike-through~~ lettering:

- A. Section 199, DEFINITIONS, § 199.1, is amended to add the following new definition:

Driver's License Road Test Facility - a building and associated paved area used by the District of Columbia Department of Motor Vehicles in connection with road tests or other tests of driving ability given to applicants for drivers' licenses or endorsements.

- B. Section 501 USES AS A MATTER OF RIGHT (SP), § 501.1, is amended by adding a new subparagraph to read as follows:

(j) **Driver's License Road Test Facility.**

- C. Section 601 USES AS A MATTER OF RIGHT (CR), § 601.1, is amended by adding a new subparagraph to read as follows:

(y) **Driver's License Road Test Facility.**

- D. Section 721 USES AS A MATTER OF RIGHT (C-2), § 721.2, is amended by adding a new subparagraph to read as follows:

(y) **Driver's License Road Test Facility.**

- E. Section 801, USES AS A MATTER OF RIGHT (C-M), § 801.7, is amended by adding a new subparagraph to read as follows:

(m) **Driver's License Road Test Facility.**

- F. Section 901, USES AS A MATTER OF RIGHT (W), § 901.1, is amended by adding a new § 901.6 to read as follows:

901.6 A Driver's License Road Test Facility, shall be permitted within the W-2 and W-3 Districts.

- G. Chapter 21, OFF-STREET PARKING REQUIREMENTS, is amended by inserting the following use in the table included in § 2101.1, SCHEDULE OF REQUIREMENTS FOR PARKING SPACES under "INSTITUTIONAL USES":

Z.C. Notice of Final Rulemaking and Order No. 04-28

Case No. 04-28

Page 4

<u>USES</u>	<u>NUMBER OF PARKING SPACES REQUIRED</u>
Driver's License Road Test Facility	
C-2-A, C-3-A	4 spaces for each employee.
C-2-B, C-2-C, C-3-B, C-3-C, C-4 C-5, SP, CR, W-2, W-3	4 spaces for each employee.
C-M, M	4 spaces for each employee.

Vote of the Zoning Commission taken at its public meeting on March 17, 2005, to **APPROVE** the proposed rulemaking: **4-0-1** (Anthony J. Hood, John G. Parsons, Kevin Hildebrand, Gregory Jefferies in favor; Carol Mitten, not present, not voting).

This order was **ADOPTED** by the Zoning Commission at its public meeting on June 13, 2005, by a vote of **3-0-2** (John G. Parsons, Kevin L. Hildebrand, and Anthony J. Hood to approve; Carol J. Mitten, having not participated, not voting; and Gregory N. Jeffries, not present, not voting).

In accordance with the provisions of 11 DCMR § 3028.9, this order shall become effective upon publication in the *D.C. Register*; that is, on _____.