

DISTRICT OF COLUMBIA
BOARD OF EDUCATION

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The District of Columbia Board of Education ("Board"), pursuant to the authority set forth in D.C. Code, 2001 Edition, Section 38-101 et seq., hereby gives notice of emergency and proposed rulemaking action taken by the Board at its meeting on December 15, 2004 to amend Chapter 9 of the Board Rules, Title 5 of the District of Columbia Municipal Regulations. The emergency action was taken and will take effect on December 15, 2004, Regular Board Meeting. The purpose of this rulemaking is to defer the public charter school application process for 2004 and 2005 until October 1, 2005, after the Board reviews and adopts the education plan for the District of Columbia submitted by the Chief State School Officer.

Emergency rulemaking is necessary because this change will cause undue financial hardship for potential charter applicants, which will cause a strain on the financial position of charter schools in the city. Furthermore, the Board Rules require the Board to publish guidelines and a timeline for the submission of applications to establish public charter schools not later than December 31st of each year.

The emergency rulemaking shall expire within 120 days of December 15, 2004, or upon publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever occurs first.

The Board also gives notice of its intent to adopt final rules in not less than thirty (30) days following publication of this notice in the *D.C. Register*.

Chapter 9 is amended as follows:

Subsection 903.1 is amended as follows:

903.1 Not later than December 31st of each year, the Board of Education shall publish guidelines and the timeline for submission of applications to establish public charter schools in September of the year following approval and one year of planning. The portion of this subsection requiring publication of guidelines and timeline by December 31st shall not apply in calendar years 2004 and 2005; provided, however, that the Board shall comply with the requirements of this subsection not later than October 1, 2005. For the year 2006 and all subsequent years, the December 31st publication date will apply.

Written comments on the proposed rulemaking are invited from interested citizens. Such comments should be addressed to Mr. Russell Smith, Executive Secretary, D.C. Board of Education, 825 North Capitol Street, N.E., Suite 9108, Washington, D.C. 20002. Copies of this rulemaking are available from the Office of the Board of Education by calling (202) 442-4289.

**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 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.

An earlier version of these emergency and proposed rules was published on September 3, 2004 at 51 D.C.R. 8691. The earlier version of the emergency and proposed rules has been modified in response to public comments received during the comment period. Three sets of written comments were received about the proposed rules. Two sets of written comments recommended amending the rules to allow licensed physician assistants to order restraint and seclusion. This change has been made throughout the rules and a definition of a physician assistant has been added to the definition section. The third set of written comments recommended that the proposed rules be conformed to the requirements of the Centers for Medicare and Medicaid services (CMS). DMH also received some verbal comments of a similar nature. The emergency and proposed rules were drafted in conformance with both CMS requirements and Joint Commission on Accreditation of Healthcare Organization requirements regarding the use of restraint and seclusion, so no additional changes were made in response to those comments. Three additional changes were made to the rules by DMH in response to some verbal comments about the rules. The first change is a clarification regarding the residential treatment centers covered by the rules and was made to section 500.7. The second change is a clarification regarding distribution of the required restraint and seclusion policy to parents and guardians of children and was made to section 502.2. The third change clarifies that the discussion with the consumer about the behavioral criteria required for the discontinuation of restraints or seclusion must be documented in a note in the consumer's clinical record that is separate from the order for restraint and seclusion. That change was made to section 506.9 with a conforming change in 506.10.

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 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 Department of Mental Health back to the District of Columbia government and requires the Department of Mental Health 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 and 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 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.

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 a consumer during transport from a hospital to District of Columbia Superior Court or Federal Court. Legally mandated restraints may also be applied in accordance with the order of a U.S. Marshal, a judge or other law enforcement official.
- 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 an attending physician's written authorization.

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 licensed to practice medicine in the District 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:
 - (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) Whether the consumer has been 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):

- (a) The consumer shall be continuously monitored by staff who shall be inside the seclusion area; and
- (b) The room shall not be locked or otherwise secured in any manner.

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's 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.

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 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 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 Restraint and seclusion shall never be used for someone who is deaf or is unable to speak
- 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 an unusual incident report to the DMH Office of Accountability; and
 - (d) Document, in the consumer's record, 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 physician's verbal order 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;