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# Newsletter

Volume 11 No. 82

November 2001

**TO:** JCAHO Accredited Residential Treatment Centers -- **For Action**  
Health Maintenance Organizations – **For Information Only**

**SUBJECT:** **Clarification of Restraint and Seclusion Requirements for a  
Psychiatric Residential Treatment Center (PRTC) Providing  
Services to Beneficiaries Under 21 Years of Age**

**EFFECTIVE:** Immediately

**PURPOSE:** To address questions submitted by providers related to the use of restraint and seclusion procedures in psychiatric residential treatment centers (PRTC) providing services to Medicaid/NJ FamilyCare or Children's System of Care Initiative (CSOCI) beneficiaries under 21

**BACKGROUND:** In Medicaid Newsletter Volume 11, Number 64, dated July 2001, the Division of Medical Assistance and Health Services (DMAHS) issued a summary, with interpretive text, of the Federal interim final rule on the use of restraint and seclusion in Medicaid-funded PRTCs. In that Newsletter, DMAHS informed providers of the Federal requirements for the Conditions of Participation related to the use of restraints and seclusion procedures in PRTCs and distributed a copy of the documentation they were required to submit attesting to their compliance with those requirements. The Division has received attestation documents from many of the providers and compliance plans from those providers who are working to come into compliance with the requirements. This Newsletter provides additional clarification for the providers in response to questions related to the rule submitted to this Division and additional clarification provided by the Centers for Medicare & Medicaid Services (CMS).

**ACTION:** Providers are requested to read the attached very carefully to determine if they need to amend their specific policies. For those facilities that filed compliance plans in response to the previous Newsletter, providers are asked to review

their compliance plans and amend them as needed. Providers may find that these clarifications will assist them in completing their compliance plans more quickly. Providers should, if their compliance plan is completed, fill out the attached Attestation Certification and submit it to the DMAHS.

Amendments to the Attestation Certification or the compliance plan should be submitted to the DMAHS within 5 working days. If you have previously completed and filed these documents and there is no change, you do not need to file them again at this time. However, if changes are necessary, copies of the Attestation Certification and the compliance plan are attached to this Newsletter for your convenience.

**PROVIDERS ARE REMINDED THAT THEY ARE REQUIRED TO NOTIFY THE  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES  
IMMEDIATELY IF:**

- 1. THERE ARE ANY CHANGES TO THE COMPLIANCE PLAN;**
- 2. THERE ARE ANY CHANGES TO THE ATTESTATION CERTIFICATION; OR**
- 3. THE COMPLIANCE PLAN IS COMPLETED**  
(Upon completion of the compliance plan, providers need to file  
the Attestation Certification)

Please fax a copy of the Attestation Certification or the updated Attachment to the Attestation Certificate (compliance plan) to: Constance Thomas, Administrator, Bureau of Policy, Fax: 609-631-4955.

The hard copy of the Attestation Certification or the updated Attachment to the Attestation Certificate (compliance plan) should be sent, postmarked within 48 hours of the fax transmission, to: Gregory Danese, Office of Provider Enrollment, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #9, Trenton, NJ 08625-0712.

**ATTACHMENTS:**

1. Most Frequently Asked Questions Related to the Restraints and Seclusions Rule
2. Attestation Certification
3. Attachment to the Attestation Certificate (compliance plan)

If you have any questions concerning this Newsletter, please contact the Office of Utilization Management at (609) 588-2721.

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB  
(BLUE TAB MARKED "5")**

## **MOST FREQUENTLY ASKED QUESTIONS RELATED TO THE RESTRAINTS AND SECLUSION RULE**

**1. Must all three criteria listed under "Drug used as a restraint" be met for drug use to be considered a restraint?**

Yes, in order for drug use to be considered a form of restraint, all three conditions in the definition must be met. These conditions are:

- The drug is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;
- Has the temporary effect of restricting the resident's freedom of movement; and
- Is not a standard treatment for the resident's medical or psychiatric condition.

**2. Should notifications be provided to and signed by the parents of youth who are already in residence, or can this requirement be phased in as new residents are moved into the facility?**

The requirements related to the use of restraint and seclusion are meant to apply to all the residents of the facility, not just those admitted on or after the federal effective date of July 21, 2001. Accordingly, the communication and notification requirements of this rule apply to the parents/guardians of the current residents. The facility should immediately communicate this information to those individuals and comply with all requirements discussed in the July 2001 Newsletter (Vol. 11, No. 64), including obtaining the signatures of the parents/guardians and placing the same in the youth's record.

**3. Does "all" staff mean *all* staff must be trained (including housekeeping, clerical and maintenance employees for example)?**

The federal interim final rule does not limit the definition of the term "staff" to specified employees of the facility. Unless and until the Centers for Medicare and Medicaid Services (CMS) provides clarification of this requirement, the facility shall ensure that anyone who may come into contact with the residents and may become involved in an incident be trained in accordance with the federal requirements.

For example, while it is not expected that a member of the housekeeping or maintenance staff would initiate a restraint, this person could be a convenient resource to help implement restraint in an emergency. In other words, a non-clinical staff person who is not classified as direct care (i.e. housekeeping, clerical or maintenance

personnel) may be the person closest to the clinical or direct care staff person who does initiate the restraint and who is in need of assistance. Therefore, all staff are required to be appropriately trained in the use of the procedures and demonstrate their capabilities prior to using the techniques with the residents. Their competency shall be demonstrated to the administration every six months, and they shall participate in further training if indicated.

The same general principle applies to CPR certification. The Division strongly encourages the facilities to require that all staff attain this certification and keep the certification current. In the event that an emergency situation does occur, valuable time can be saved if the people in the area are trained to provide the needed intervention. Formal CPR certification is obtained by passing a course provided by certified CPR trainers and this certification is valid for one year. Recertification should be completed annually to ensure that all employees are competent to provide this intervention.

**4. In the case of multiple or frequent episodes requiring the use of restraint/seclusion interventions, how often must a provider call the parent(s)?**

The rule states that the parents or legal guardians should be notified each time a restraint or seclusion occurs. However, if the parent/legal guardian indicates to the facility that they do not wish to be notified each time, or wish to be notified at a pre-arranged time, for example once a week, or at the next treatment team meeting, these requests can be accommodated. These issues should be discussed by all interested parties and a course of action agreed upon at the time the initial treatment plan is developed. The decision regarding this course of action shall be included in the youth's treatment plan. The participation of all interested parties arriving at the decision, including the youth and parent, must be documented in the youth's record. Any changes to this agreed upon course of action shall be approved by the treatment team and reflected in the youth's record. There may be times when contacting the parent and other official entities are necessary, for example, in the case of the injury or death of the resident or other person as a result of the incident, multiple notifications are mandated by the federal requirements (parent, guardian, CMS, DYFS, and the police).

**5. What notification procedures should we follow regarding parental notification if the parent either does not participate as a partner in treatment or if there are abuse or other issues?**

If the rights of the youth's parents have been limited or terminated by the courts due to abuse or other issues, the courts will generally designate some other person to act in the place of the parent(s). Upon admission to the facility, all interested parties should discuss these issues and a course of action agreed upon and documented in the youth's record. Any changes to this agreed upon course of action shall be approved by the treatment team and reflected in the youth's record.

**6. Can both (resident and staff) debriefings be accomplished at the same time? One directly after the other?**

The rule allows for flexibility in the timing of the debriefings, as long as both occur within 24 hours after the incident. The debriefings must be held separately, since each debriefing session has a unique agenda, focusing on processing and evaluating separate aspects of the incident.

The first debriefing is to include the staff and resident involved in the incident and is designed to help those individuals process the events and develop a plan to prevent the future use of the intervention. Realistically, this often occurs very shortly after the end of the incident, involving the staff on duty and the residents that were involved in and/or witnessed the incident.

The second debriefing, attended by administrative and supervisory clinical staff, is generally held during the "regular business hours" of the facility, includes the staff members involved in the incident, and focuses on the appropriateness of the intervention used. This debriefing is intended to discuss the emergency safety intervention used, including:

- Identifying the factors that lead to the use of the intervention;
- Identifying alternative interventions that could have been used;
- Identifying any procedures that staff could implement to prevent any reoccurrence of the use of the restraint or seclusion; and
- Identifying the outcome of the intervention, including any resulting injuries to residents or staff members.

If a staff member involved in an incident is unable to attend the debriefing, the debriefing should be held with all available staff as appropriate. The facility should document why the staff member was not available. Reasonable cause for the staff person not attending this debriefing may include, but is not limited to, scheduled vacation time, sick leave, scheduled day off, or if the attendance of the staff person was not considered to be in the best interest of the youth. A summary of the debriefing, including, but not limited to, any changes in the resident's treatment plan or staff work duties made as a result of the incident, shall be communicated to the staff immediately upon their return to work.

A summary of all proceedings and the results of both debriefings must be documented in the resident's record, including, but not limited to, any recommended changes to the treatment plan. No changes to the treatment plan may be made without the approval of the treatment team.

**7. If there is more than one emergency safety intervention used in the same incident, is the provider required to hold separate debriefings for each intervention?**

No, the debriefing requirements are related to the number of incidents, not the number of interventions used. However, during the debriefings all interventions that were used must be individually evaluated as part of the discussion of the incident.

One example is if a personal hold is being used to prevent a resident from physically assaulting another resident and this intervention is not proving effective and, therefore, a mechanical restraint is used. When discussing the incident, staff and residents involved in the debriefing must discuss the progression from one intervention to another and the overall effectiveness of the interventions that were utilized.

**8. Who can order/authorize the use of restraint or seclusion? Who can receive the verbal order/authorization?**

The resident's treatment team physician must order the use of **mechanical or drug restraint or seclusion**. If someone other than the treatment team physician orders the mechanical or drug restraint or seclusion, the treatment team physician must be contacted as soon as reasonably possible and informed that the order was placed.

- For in-state facilities, if the treatment team physician is unavailable, a physician, advance practice nurse, or physician's assistant may order the use of restraint or seclusion.
- Out-of-state facilities must follow the state Medicaid program requirements of the state in which they are located.

The resident's treatment team physician should authorize the use of **personal restraint**. If someone other than the treatment team physician authorizes the personal restraint, the treatment team physician must be contacted as soon as reasonably possible and informed that the authorization was given.

- If the treatment team physician is unavailable, then for in-state facilities, a licensed, professional member of the youth's treatment team may authorize the use of a personal restraint.
- Out-of-state facilities must follow the state Medicaid program requirements of the state in which they are located.

For in-state facilities, the use of on-call or per diem staff is allowable, however the treatment team physician must be notified as soon as reasonably possible (generally the next regular business day).

For in-state facilities, verbal orders for the use of mechanical restraint, drug restraint or seclusion must be received by an advanced practice nurse, registered nurse, or physician's assistant (Out-of-state facilities must follow the state Medicaid program requirements of the state in which they are located.)

Please refer to Medicaid Newsletter Volume 11, No. 64, dated July 2001, for a more complete discussion of the requirements related to the placing and receiving of orders for the use of restraint and seclusion.

**9. Regarding the receipt of the orders, what is the definition of "immediate"?**

Medicaid Newsletter Volume 11, No. 64, dated July 2001 stated that the orders/authorization must be received while the intervention is being initiated by staff or immediately after the emergency safety situation ends. This is meant to require that the order or at a minimum the verbal order, be received as soon as possible.

One example is if the residents are becoming involved in verbal altercations that are causing the youth involved to exhibit increasingly agitated and threatening behaviors. The non-physical interventions that the staff are using in an attempt to diffuse and stabilize the situation are proving to be non-effective. The treatment team physician or other appropriate clinical staff member should be contacted, apprised of the situation, and should order/authorize the use of an emergency safety intervention as appropriate. Although it is preferred that the authorization/order be received prior to the implementation of the restraint or seclusion, it is understood that safety and time concerns do not usually allow for that scenario, especially in light of the federal requirement that these orders not be placed as standing orders. We would anticipate that the contact for the authorization/order for the intervention be placed as soon as possible after the initiation of the intervention, and in no case later than one hour after the initiation of the intervention.

**10. What is the difference between "restraining" and "separating" two individuals involved in an altercation?**

Like many aspects of providing quality mental health care to youth, this is one of those areas where the judgement of the direct care staff is of paramount importance. We realize that when more than one youth is in the same area, there may be times that those youth attempt to settle their differences physically. It is understood that an integral part of the daily responsibilities of the direct care staff is to prevent these altercations from happening, something that is not always accomplished by non-physical interventions on the part of the staff. After consultation with the CMS, this Division understands that the federal requirements were not intended to so strictly regulate brief and/or incidental physical contact that may be required to separate two youths involved in a physical altercation. Rather, the regulations are intended for those

times when the level of physical involvement of the staff member goes beyond the reasonable level of brief physical contact.

For example, during a basketball game, two youths become involved in a verbal altercation, which quickly escalates into a physical altercation (pushing and shoving each other, attempted punches or kicks, etc.). In order to avoid further physical contact, a staff member steps between the youth, pushing them apart and telling them to stop the behavior. If the youth immediately comply with that request, this would not be considered a restraint. If, however, one or both of the youth involved did not immediately comply with the request to stop the behavior, resulting in the use of a therapeutic hold to prevent further physical assault on either the other youth or the staff person involved, that would be considered a restraint.

- All incidents are required to be documented and such documentation placed in the youth's record.
- The documentation of incidents where the physical contact is deemed to be incidental and not a restraint must include justification for the classification.

The Division acknowledges that this is an area open to interpretation, and therefore encourages all providers to err on the side of caution. That is, if after an incident it is unclear whether this was or was not a restraint, treat it as a restraint. This will ensure that the youth's rights are protected and that his or her best interests are served.

#### **11. Is a brief hold intended to escort or comfort a resident considered a personal restraint?**

No, the CMS received comments that their original definition of personal restraint was so broad that staff would be prohibited from touching a resident at all for the purposes of providing comfort or escorting the resident. This was not the intention of the CMS and the definition of personal restraint was revised in the interim final rule to reflect that. As communicated in the Medicaid Newsletter Vol. 11, No. 64, dated July 2001, the definition of personal restraint is as follows:

"Personal restraint" means the application of physical force without the use of any device, for the purpose of restricting the free movement of a resident's body. Personal restraint does not include briefly holding, without undue force, a resident in order to calm or comfort the resident or holding a resident's hand or arm in order to safely escort a resident from one area to another."

For example, consider the two youths involved in the basketball game in the example used in #10. Once the two youths have been separated and the physical altercation is over, tempers are still high and the verbal altercation continues (yelling threats at each other etc.). A staff person approaches one of the youths and places a hand on their arm, escorting them to another part of the campus by walking with them, holding their

arm or elbow as they walk. The youth does not resist this casual physical contact and allows himself or herself to be led by the staff person away from the basketball court and back to the dormitory where the staff person talks to the youth until the youth is calm. This is not considered personal restraint. If the youth resists the casual physical contact of the escort and the staff person then increases restrictive physical contact in order to restrain the youth, then this would be considered use of physical restraint.

**12. What is the definition of "clinical staff"? Does this refer only to licensed clinicians, or can this apply to the direct care staff?**

Clinical staff refers to professional members of the treatment team who are licensed in accordance with the requirements of the appropriate state licensure board.

Direct care staff, unless licensed as a general health or mental health professional, are not considered clinical staff even if the facility includes them as members of the youth's treatment team.

**13. Do the requirements related to the use of restraint and seclusion apply while the residents are participating in school programs on the campus of the residential treatment center?**

If the school on the campus of the residential treatment center is operated by that facility, and is providing educational services to Medicaid/NJ FamilyCare-eligible youth as part of their inpatient psychiatric services, the facility is responsible for ensuring that the restraint and seclusion standards are met while the students are in the school. This would apply to a school program that is operated by the facility or is part of the administrative purview of the facility but is physically off the campus of the facility.

If the school on the campus occupies space on the campus, but is operated by the local school district, the facility is responsible for ensuring that the standards are met if any of their residents attend the school. The residents are considered "inpatients" and are considered under the continuous care of the facility even while attending the school. In this instance, the school itself would not be subject to the CMS's restraint and seclusion rules, but the facility is responsible for ensuring that the residents are not placed in the custody of a school that does not comply with the restraints and seclusion rules or the facility would then be out of compliance.

**14. Are all the residents of the facility protected under this rule?**

Yes, all residents of the facility, regardless of whether or not they are Medicaid/NJ FamilyCare eligible, are provided the same protections under this rule. This includes, but is not limited to, those youth who are receiving mental health services as part of the CSOCI.

**ATTESTATION CERTIFICATION**

I, the undersigned, certify that I am the Chief Executive Officer, or designee, of \_\_\_\_\_, a Psychiatric Residential Treatment Center (PRTC), which provides inpatient psychiatric services to Medicaid/NJ FamilyCare/Children's System of Care Initiative (CSOCI) beneficiaries under the age of 21.

Based upon my personal knowledge and belief, I attest that the responses on the attached Attachment to the Attestation Certification are true and correct, and that \_\_\_\_\_ currently meets, and will continue to meet, the attached requirements for the use of restraints and seclusion in PRTCs providing services to individuals under the age of 21. I agree that if the facility fails to meet any of these requirements, I will notify the Division of Medical Assistance and Health Services immediately.

I understand that the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), or its authorized representative, has the right to conduct an on-site survey at any time to validate whether the statements made on the attached list of requirements are true. I understand that any falsification, omission, or concealment of material fact in the attached document(s) may subject each of us to civil or criminal liability.

I agree that the facility will submit a new attestation to the Division of Medical Assistance and Health Services or the appropriate state Medicaid agency, if there is a change in the individuals serving as Chief Executive Officer.

I agree that the facility will notify the applicable State Medicaid agency if the facility, to the best of our knowledge, no longer complies with the requirements related to restraint and seclusion.

**Chief Executive Officer/Designee**

Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Address of the facility: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone number: \_\_\_\_\_

New Jersey Medicaid Provider Number: \_\_\_\_\_

**ATTACHMENT TO THE ATTESTATION CERTIFICATION**

The \_\_\_\_\_ meets the following Conditions of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21 as defined in 42 CFR Subpart G: §§483.350 – 483.376.

Yes  No Has in place policies which define emergency safety interventions i.e., the use of restraint and/or seclusion, consistent with the definitions at 42 CFR 483.352;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has in place policies consistent with 42 CFR 483.356 which protect the safety and rights of individuals, including notification of the individual or their parent/legal guardian;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has the resources available and the procedures consistent with 42 CFR 483.358 in place related to ordering, and receiving the order for, the use of restraints and/or seclusion and the appropriate timeframes for the use of these interventions;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has policies and procedures in place consistent with 42 CFR 483.360 related to consulting with the individual's treatment team physician when ordering the use of restraints and/or seclusion;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENT TO ATTESTATION CERTIFICATION**

Yes  No Has in place procedures consistent with 42 CFR 483.362, for the monitoring and assessment of beneficiaries who are in restraint and immediately after the use of restraint;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has in place procedures consistent with 42 CFR 483.364, for the monitoring and assessment of beneficiaries who are in seclusion and immediately after the use of seclusion;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has in place a procedure consistent with 42 CFR 483.366, to notify a beneficiary's parent(s) or legal guardian(s) when restraint or seclusion are used with that beneficiary;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has in place a procedure consistent with 42 CFR 483.370 regarding the debriefing of all individuals involved in the use of the restraint or seclusion;

If "No," describe compliance plan (include target dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENT TO ATTESTATION CERTIFICATION**

Yes  No Has a plan in place regarding medical treatment for injuries resulting from the use of restraint or seclusion consistent with 42 CFR 483.372;

If "No," describe compliance plan (include target dates): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has in place a procedure consistent with 42 CFR 483.374 and all applicable State statutes and rules for reporting all deaths and serious injuries or occurrences to the appropriate parties;

If "No," describe compliance plan (include target dates): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Has in place policies consistent with 42 CFR 483.376 related to the training and certification of the staff involved in the use of emergency safety interventions.

If "No," describe compliance plan (include target dates): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Identifying Information**

Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone number of Facility: \_\_\_\_\_

New Jersey Medicaid Provider Number: \_\_\_\_\_

Name of Chief Executive Officer: \_\_\_\_\_

Signature of Chief Executive Officer: \_\_\_\_\_