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Newsletter

Volume 12 No. 72 **September 2002**

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

SUBJECT: **Additional Clarification Regarding the use of Restraints and Seclusion in JCAHO-Accredited Residential Treatment Centers**

EFFECTIVE: Immediately

PURPOSE: To address additional questions submitted by providers related to the use of restraint and seclusion procedures

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 a Medicaid-funded Psychiatric Residential Treatment Center (PRTC). In that Newsletter, DMAHS informed providers of the Federal requirements of the Conditions of Participation related to the use of restraints and seclusion procedures in PRTCs. Attached to the Newsletter was a copy of the documentation providers were required to submit to the Division attesting to their compliance with the requirements at 42 CFR, Subpart G §§483.350 – 483.376.

In Medicaid Newsletter Volume 11, Number 82, the Division provided additional clarification for the providers in response to questions that were raised related to the rule and shared with providers additional clarification provided by the Centers for Medicare & Medicaid Services (CMS). This Newsletter addresses additional questions that the providers have raised since the publication of the previous two newsletters.

ACTION: Attached to this Newsletter is the same list of "Most Frequently Asked Questions Related to the Restraints and Seclusion Rule" that was attached to

Medicaid Newsletter Volume 11, Number 82, dated November 2001; however the list has been revised. ***The revisions to the answers and new question/answer set #15 are in bold italics so that you can identify them easily.*** Please carefully review this information and amend your policies as needed to ensure compliance with the requirements.

The revised language includes the following information:

- Regarding the debriefings required of the staff and residents after the use of an emergency safety intervention, a summary of the debriefings involving the resident must be documented in the resident's file. The debriefings concerning the staff and the administration of the facility should be maintained in an appropriate location in the facility or staff person's file, not in the resident's file.

- A member of the resident's treatment team who is designated by the facility as authorized to receive the order may receive verbal orders for the use of personal restraint.

- The monitoring and assessment requirements in 42 CFR 483.362 do not require that a nurse and/or doctor be on grounds at all times. The Senior Staff Member on duty may do the initial evaluation, for personal restraint only, provided that there is a nurse or doctor on call and that they are contacted and informed of the situation. If the resident is not visually observed by a medical staff person shortly after the end of the emergency intervention, the resident must be evaluated by a qualified medical professional the next day, even if no serious medical condition, as indicated by physical or emotional symptoms, was initially evident.

ATTACHMENT:
Most Frequently Asked Questions Related to the Restraints and Seclusions Rule (Revised September 2002)

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

REVISED September 2002

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;
- The drug has the temporary effect of restricting the resident's freedom of movement; and
- The drug 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. ***We are advising facilities that they*** shall ensure that anyone who may become involved in an incident be ***appropriately*** trained ***regarding emergency safety situations and interventions***.

All staff members who may not be directly involved in the use of restraints and seclusion techniques should be trained in the proper protocols and procedures to secure help and assistance to quickly notify direct care or clinical staff to defuse a situation or to secure help and assistance for staff who are directly involved in the use of an emergency safety intervention.

For example, while it is not expected that a member of the housekeeping or maintenance staff would ***respond to an emergency safety situation by initiating a restraint,*** this person could be a convenient resource to help ***identify*** an emergency ***situation before such interventions become necessary. These individuals should be trained to be aware of environmental factors, which may serve as warning signs that an emergency situation may occur. These individuals should also be informed of the procedures used to notify the appropriate staff that an intervention may be needed.***

The same general principle applies to CPR certification. ***As in the case of the use of restraint and seclusion techniques, only the clinical and direct care staff, as well as other staff who may become involved in the use of restraint and seclusion techniques are required to be certified. All other staff members (clerical, food service, groundskeepers, administration, etc.) should be made aware of how to quickly contact an appropriate person to administer CPR.*** In the event that an emergency situation does occur, valuable time can be saved if the people in the area are trained ***to get help as quickly as possible***.

Facilities should use their discretion regarding what other staff, who are not required to be trained, they may want to be trained in emergency safety interventions and/or CPR.

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 must 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 must 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 is necessary, for example, in the case of the injury or death of the

resident or other person as a result of the incident, where 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 should be agreed upon and documented in the youth's record. Any changes to this agreed upon course of action must 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 led 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 any 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 any absent 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 absent staff immediately upon their return to work.

A summary of all proceedings and the results of ***the first (staff and resident involved) debriefing only, <u>not</u>*** *both debriefings, must be documented in the resident's record, including, but not limited to, any recommended changes to the treatment plan.* ***A summary of the proceedings and results of the second debriefing (staff and administration involved) should be maintained in the records of the facility in an appropriate location, such as an incident log and/or the staff members personnel file as appropriate.***

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.

For example, if a personal hold is being used to prevent a resident from physically assaulting another resident and this intervention is not proving effective, a mechanical restraint may be 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 all 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.

For New Jersey facilities, a member of the treatment team who is not precluded from receiving a verbal order, and who is authorized by the facility to receive the order, must personally receive the verbal order. This can include any member of the treatment team designated by the facility. (Out-of-State facilities must follow the state Medicaid program requirements of the state in which they are located.)

For example, if the residents are becoming involved in verbal altercations that are causing them to exhibit increasingly agitated and threatening behaviors, a series of interventions may be attempted. If the non-physical interventions that the staff are using in an attempt to defuse 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. ***Such contact should be initiated by a member of the child's treatment team who is not precluded from receiving a verbal order, and who is authorized by the facility to receive the order.***

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 youths 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 the staff intervention was or was not a restraint, treat the intervention 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 the youth's arm, escorting him or her to another part of the campus by walking with him or her, 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 health or mental health professional, are not considered clinical staff, even if they are 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 also 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. If the facility does not ensure this, the facility would then be out of compliance with the rules.

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.

15. Does the monitoring and assessment of a resident's physical and mental state require that a nurse and/or a clinician be on site at all times? (42 CFR 483.362)

For in-State facilities, you are not required to have a qualified medical professional on grounds at all times. It is permissible for a resident to be evaluated by the Senior Staff Member on duty at the time immediately after the use of PERSONAL RESTRAINT. This person is generally known as the Shift Supervisor or some similar title. In the case of SECLUSION, DRUG RESTRAINT, OR MECHANICAL RESTRAINT, a qualified medical professional must be present at all times, and must perform all monitoring and evaluations personally.

In addition, there must be a qualified medical professional on-call who can make a determination if a more comprehensive physical or mental health evaluation is indicated.

When the evaluation is not visibly observed by a qualified medical professional, a qualified medical professional must see the resident the next day, even if no serious condition, as indicated by physical or emotional symptoms, was initially evident.

The evaluation of a resident following the use of PERSONAL RESTRAINT ONLY should basically follow these steps:

Supervisor assesses the resident, noting any unusual behavior and/or physical symptoms in the incident report (i.e. dizziness, reports of blurred vision, losing consciousness, a black eye, a skinned knee, a sore ankle, refusal to communicate, excessive agitation, suicidal threats, attempts to harm themselves, etc.).

The Supervisor contacts the medical professional on call and describes the condition of the resident over the phone, providing any answers to any additional questions the medical professional may ask, and/or letting the medical professional speak on the phone with the resident.

The medical professional will make a judgement based on the information given. This may result in the resident being transferred to the emergency room, the medical professional deciding to come on grounds for a further evaluation, or advising the staff on duty to watch for additional signs and notify him/her if any change in the resident's condition occurs.

EXAMPLE #1: In the process of placing a personal restraint on a resident involved in a fight with another resident, the resident resists, sending the staff and the resident falling to the floor, causing the resident to twist his or her ankle during the fall. The supervisor calls the medical professional on call and gives a brief description of what happened. The medical professional asks the supervisor and/or the resident, to describe the appearance of the ankle (swollen, bruised) and the amount of pain to the ankle if the resident moves it. Based on the answers given, the medical professional determines that off-site care is not necessary. The staff member on duty is advised to keep the resident off their feet, and apply an ice pack to the ankle, keeping it elevated.

EXAMPLE #2: Now, consider the same situation, with the exception that the answers that the medical professional received from the staff and/or resident cause him or her to believe that the resident's ankle required additional evaluation. In this case, the medical professional would either come on grounds to conduct a further evaluation of the resident's condition or advise the staff to take the resident to the local emergency room, or other medical facility the residential center has a relationship with, for appropriate medical evaluation and treatment.

EXAMPLE #3: A resident is placed in a personal restraint to prevent him or her from harming another person. Once the resident appears calm and the other person has been removed from the area, the personal restraint is ended. After the personal restraint is over, the resident sits on the couch, refusing to talk to the staff or other residents. She begins to cry and cannot be consoled or calmed. The supervisor calls the medical professional on call and describes the behavior and the preceding events (i.e. the threats to the other person, what preceded those threats if known, and the personal restraint). After talking to the supervisor and, if cooperative, the resident, the medical professional on call will make a determination for further action. This may include, but is not limited to, coming on grounds to assess the situation, calling the resident's counselor if that person is available, or arranging to transfer the resident to a local crisis center.

IMPORTANT POINTS TO REMEMBER

- ***In the case of MECHANICAL RESTRAINT, DRUG RESTRAINT OR SECLUSION, monitoring and evaluation by non- medical staff is not permissible; a qualified medical professional must monitor the implementation of the intervention and perform all required evaluations in person.***

- ***To ensure that no serious medical situations are missed, the medical professional on call must be notified of every use of PERSONAL RESTRAINT, even if the resident appears to be ok.***

- ***The senior staff member on duty at the time of the incident must ensure that all medical recommendations are adhered to and must document the incident in the facility's daily activity log.***