CHAPTER 65E-20
FORENSIC CLIENT SERVICES ACT REGULATION

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65E-20.002 Definitions.

(1) Act: the Forensic Client Services Act.

(2) Advanced Registered Nurse Practioner: as defined in Section 464.003(7), F.S.

(3) Client Representative: the client's attorney of record, next of kin, or any other relative or person designated by the client. If none is designated, the attorney of record shall be the client representative.

(4) Commitment: a court ordered involuntary hospitalization or placement of a forensic client according to the procedures of this act. It does not include voluntary admission of any client.

(5) Individual: a person with a mental illness who has been charged with a felony offense and is being served in a forensic facility. The term is synonymous with "client," "patient," or "resident."

(6) Personal Safety Plan: a plan regarding strategies that the individual identifies as being helpful in avoiding a crisis. The plan also lists identified triggers that may signal or lead to agitation or distress.

(7) Physician: A medical practitioner licensed under Chapter 458 or 459, F.S., who has experience in the diagnosis and treatment of mental and nervous disorders.

(8) Recovery Plan: may also be referred to as a "service plan" or "treatment plan." A recovery plan is a written plan developed by the individual and his or her recovery team to facilitate achievement of the individual's recovery goals. This plan is based on assessment data, identifying the individual's clinical, rehabilitative and activity service needs, the strategy for meeting those needs, documented treatment goals and objectives, and documented progress in meeting specified goals and objectives.

(9) Recovery Team: may also be referred to as "service team" or "treatment team." A recovery team is an assigned group of individuals with specific responsibilities identified on the recovery plan who support and facilitate an individual's recovery process. Team members may include the individual, psychiatrist, guardian, community case manager, family member, peer specialist, and others as determined by the individual's needs and preferences.

(10) Restraint: is defined in Section 916.106(14)(a), F.S. A drug used as a restraint is defined in Section 916.106(14)(b), F.S. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

(11) Seclusion: is defined in Section 916.106(16), F.S.

(12) Seclusion and Restraint Oversight Committee: a group at an agency or facility that monitors the use of seclusion and restraint at the facility. The purpose of this committee is to assist in the reduction of seclusion and restraint use at the agency or facility. Membership includes, but is not limited to, the facility administrator/designee, medical staff, quality assurance staff, and a peer specialist or advocate, if employed by the facility or otherwise available. If a peer specialist or advocate is not employed by the facility, an external peer specialist or advocate may be appointed.

(13) Treatment: mental health services which are provided to individuals, individually or in groups, including: counseling, supportive therapy, psychotherapeutic medication, intensive psychotherapy, or any other accepted therapeutic process.

(14) Walking Restraint: a type of restraint device that allows an individual limited mobility but still prevents harm to self or others. It is intended as a less restrictive form of restraint (also referred to as an "ambulatory" restraint).

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.106, 916.106(14), (16) FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.002, Amended 1-28-10.

65E-20.003 The Right to Individual Dignity.

In addition to those elements of dignity and respect enumerated in Section 916.107(1), F.S., every forensic client is entitled to the following:

(1) Freedom from neglect or abuse;

(2) Safe living conditions and protection from harm;

(3) Appropriate seasonal attire; and

(4) The opportunity to be outdoors and to participate in physical exercise at regular intervals, in the absence of medical or security considerations.

Rulemaking Authority 916.1093 FS. Law Implemented 916.107(1) FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.003, Amended 1-28-10.

65E-20.004 The Right to Treatment.

(1) Within existing resources, the department, and agencies with whom it has contractual service provider agreements, shall not deny or delay mental health services to any forensic client under any circumstances, except where allowed by law.

(2) Forensic clients committed pursuant to Chapter 916, F.S., shall be given within 24 hour of admission, and at least annually thereafter, a physical examination by a licensed physician or other health practitioner as authorized by law. In the event of refusal of the examination by the client, the procedures for emergency treatment shall apply.

(3) If a forensic client has been adjudicated incompetent under the provisions of Chapter 744, F.S., a copy of the client's individualized treatment or rehabilitation plan shall be provided to the legal guardian within 30 days of the client's admission.

(4) Every reasonable effort shall be made to communicate treatment information to the client in a language the client understands.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107(2) FS. History–New 9-29-86, Formerly 10E-20.004.

65E-20.005 The Right to Express and Informed Consent.

(1) Informed Consent.

(a) Upon admission to a forensic facility, a client, or the person authorized to provide consent for treatment on behalf of the client, shall be asked to sign an "Authorization for Treatment" (HRS-MH Form 3042, Jan. '85) which is incorporated herein by reference. The signed authorization form establishes express and informed consent.

(b) The facility shall not initiate treatment until the required authorization form is signed, except in those cases where emergency treatment is ordered by a physician as provided in Section 916.107(3), F.S.

(2) Specialized Consent Requirements and Procedures.

(a) In each separate instance where surgical procedures require the use of a general anesthetic, special written consent shall be obtained, prior to performing the procedure, from the client or the person legally authorized to provide consent if the client is a minor or has been declared incompetent under the provisions of Chapter 744, F.S. The "Authorization for Surgical Procedures Requiring General Anesthetic" (HRS-MH Form 3055, Jan. '85), which is incorporated herein by reference, shall be used to establish consent pursuant to Section 916.107(3)(b), F.S.

(b) In each separate instance where electroconvulsive treatment is to be used, pursuant to Section 458.325, F.S., there must be specific written informed consent from the client, or the person legally authorized to provide consent if the client is a minor or has been declared incompetent under the provisions of Chapter 744, F.S., prior to performing the procedure by using the "Authorization for Electroconvulsive Treatment" (HRS-MH Form 3057, Jan. '85), which is incorporated herein by reference.

(c) The provision of psychosurgical or electroconvulsive treatment requires the written concurrence of a second, nonattending physician pursuant to Section 458.325, F.S.

(d) Written consent for routine nonpsychiatric medical procedures or treatment shall be accomplished by having the client, or the person legally authorized to provide consent on behalf of the client, sign the "Authorization for Nonpsychiatric Medical Procedures" form (HRS-MH Form 2008, Aug. '86), which is incorporated herein by reference.

(e) Any authorization for treatment given by an administrator of a forensic facility or his designated representative pursuant to

Section 916.107(3)(b), F.S., shall be clearly documented in the client's clinical record and the client's guardian, if applicable, and next of kin shall be notified as soon as possible.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107(3) FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.005, Amended 9-29-98.

65E-20.006 The Right to Communication, Abuse Reporting and Visits.

(1) Communication.

(a) Every forensic client shall be allowed to receive correspondence and may send an unlimited number of letters.

1. Each facility shall provide stationery and writing implements for indigent forensic clients, and shall pay postage on up to three outgoing pieces of correspondence each week.

2. The term "correspondence" shall not include parcels or packages. Forensic facilities shall develop policies and procedures to provide for the inspection of parcels or packages, and for the removal of contraband items for health or security reasons prior to the contents being given to the client, and shall include a system in which items removed as contraband are inventoried, notification given to the client of what was removed and why, as well as a process to either store the contraband material at the facility, or arrange to have it picked up or mailed to a person designated by the client or, in cases of contraband, transferred to the appropriate law enforcement agency.

(b) Upon admission, a forensic facility shall advise clients of the facility of rules governing written and verbal communications, including telephone calls and visitation between clients and others outside the facility.

(c) A forensic client's right to communicate shall not be restricted as a means of discipline, punishment, or to serve only the convenience of facility staff.

(2) Abuse Reporting.

(a) All facilities providing mental health services, pursuant to Chapter 916, F.S., shall provide for the reporting of abuse in accordance with the provisions of Chapter 415, F.S., "Protection from Abuse, Neglect, and Exploitation".

(b) Each forensic facility as defined in Chapter 916, F.S., shall provide:

1. A verbal and written explanation to each client of the procedures for reporting an alleged abuse,

2. Client access to a telephone for the purpose of reporting an alleged abuse, which should be immediate for all clients except those in seclusion or restraints, in which case access should be as soon as is practical, but in no event shall exceed 4 hours from the time the client requests access to the telephone to report an alleged abuse, and

3. The posting, in plain view, of:

a. A copy of the abuse reporting procedure,

b. The telephone number of the abuse registry.

(c) All forensic facilities shall maintain verification that all staff understand and are aware of the abuse reporting procedures as a condition of employment.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107(5) FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.006.

65E-20.007 The Right to Vote in Public Elections.

(1) Any forensic client not adjudicated incompetent under the provisions of Chapter 744, F.S., or otherwise disqualified by law, and meeting the legal age and residency requirements of the state, shall be assisted in registering to vote and in voting if he so requests.

(2) A client who is properly registered to vote in a county other than the county of placement, shall be assisted in making application for an absentee ballot in that county if he so requests. A client who is not registered to vote shall be assisted in registering in the county of his permanent residence, if he so requests.

(3) If a client requests assistance in voting, registering, or in getting information about voting requirements, staff at the facility shall assist him in obtaining the information.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107(7) FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.007.

65E-20.008 The Right to Confidentiality of a Forensic Client's Clinical Record.

(1) The clinical record of every forensic client is confidential and shall be clearly indicated as such. Other than the exceptions

noted in Section 916.107(8), F.S., and as implemented below, information may only be released when the client or his guardian, if a minor or adjudged incompetent under the provisions of Chapter 744, F.S., signs an "Authorization for Release of Information" (HRS-MH Form 3044, Nov. '81), which is incorporated herein by reference, or the "Continuity of Care Management System (CCMS) Consent to Share Information" (HRS-MH Form 3095, Jan. '86), which is incorporated herein by reference. This authorization must contain the name of the person or agency to whom the information is to be released, the purpose of the release, and the time period within which the authorization is valid.

(2) Information received on a privileged and confidential basis from third parties, other than an HRS treatment facility or Florida community provider, shall be restricted from release when the administrator determines that the information would adversely affect the client's treatment or violate the rights of another person. Every record which is released shall indicate where third party privileged and confidential records were withheld.

(3) When a clinical record, or any part thereof, is released to any person or agency for any purpose, each page, or part thereof, shall be marked as follows: "Confidential and Privileged Information for Professional Use Only".

(4) All forensic clients have the right of reasonable access to their own mental records on a continuing basis, except for privileged and confidential records from third party sources. The right of reasonable access shall be clarified through written policies maintained by each facility. A client's attorney shall have reasonable access to records upon written authorization from the client.

(5) If a request is made by a parent or legal guardian for the client's treatment plan, or current physical and mental condition, the request shall be made in writing and signed.

(6) Whenever a forensic client has declared an intention to harm others, such declaration may be disclosed to the person or persons affected. Law enforcement agencies, in the area where the person or persons whom the client has declared an intention to harm reside, may be notified of such declaration. Such notification shall be done by the facility administrator, or his designee, and shall be documented in the client's clinical record.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107(8) FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.008.

65E-20.009 The Right to Be Informed.

(1) All forensic clients have the right to timely and meaningful information about their rights. Each client shall be informed of his rights as a forensic client in a forensic facility at the time of admission.

(2) Each forensic facility shall post, in a conspicuous place or places, and in a form that is legible, a listing of all forensic client rights.

(3) Each forensic facility shall maintain on the premises of the treatment site, an up-to-date copy of Chapter 916, F.S., and an up-to-date copy of these rules, and shall have these documents available for inspection upon the request of a client, the client's representative, the client's guardian, friends or relatives of the client.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107 FS. History–New 9-29-86, Formerly 10E-20.009.

65E-20.010 Transportation.

(1) Department forensic clients shall be transported separately from Department of Corrections felons who are being transported to and from correctional facilities.

(2) All transportation provided shall be consistent with the needs of clients and the condition of clients being transported, as specified by the sending facility. Any company contracting with the governing board of a county to transport forensic clients shall comply with requirements to ensure the safety and dignity of the client. Such requirements shall be specified in the contract and shall include, but not be limited to the following:

(a) All transport vehicles will be equipped with a type 1A10BC fire extinguisher, seat belts, and two-way communication radio.

(b) Staff having the responsibility for transporting clients shall be trained, experienced, and otherwise qualified to transport mentally ill persons. This training shall include, but not be limited to, the training approved by the department for law enforcement officers involved with the care and handling of clients under Chapter 394, F.S.

(c) A minimum of two staff members shall be used in the transporting of clients.

(d) Staff members transporting forensic clients shall not wear firearms in the vehicle.

(e) The length of time for transporting clients shall not exceed 12 hours per day.

(f) Rest stops shall be made at regular intervals during the transporting of clients.

(g) Clients shall be dressed in appropriate seasonal attire.

(h) Nutritious meals shall be provided at appropriate times during the transporting of clients.

(i) Physical restraints, such as canvas cuffs, shall be used only when necessary to protect the clients from injury to themselves or others.

(j) All staff members who accompany clients shall have knowledge of techniques in handling volatile clients.

(k) Any driver of a vehicle used in transporting mental health clients shall have a valid Florida Class E (non-commercial) license when operating a vehicle designed to transport 15 or fewer individuals including the driver. The Class C commercial license will be needed when operating a vehicle with a Gross Vehicle Weight Rating of less than 26,001 pounds designed to transport more than 15 persons including the driver. When passengers are transported in a vehicle with a Gross Vehicle Weight Rating of 26,001 pounds or more a Class B commerical license with a Passenger endorsement will be needed. All drivers will be responsible for ensuring they have the appropriate licenses and endorsements.

(l) Any vehicle used in transporting clients shall be maintained and operated in accordance with Chapter 916, F.S., and in a manner that protects the clients' rights, dignity, and physical safety.

(m) The number of persons in any vehicle used in transporting clients shall not exceed the manufacturer's recommended seating capacity.

(n) Any unusual incidents occurring during the client transport process shall be reported immediately upon arrival at the treatment facility to the sherif's department, an originating receiving or treatment facility, if applicable, and the governing board of the county.

(o) The transport company shall ensure the confidentiality of the transport record.

(p) Civil patients committed under Part I of Chapter 394, F.S., and forensic clients committed under Chapter 916, F.S., who are assigned to reside in secure facilities, shall be transported separately. Forensic clients who reside in civil facilities may be transported with civil patients.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107(10) FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.010, Amended 9-29-98, 11-29-12.

65E-20.011 Receipt of Commitment Orders and Required Documentation.

(1) Commitment orders pertaining to any person committed to the Department of Children and Family Services pursuant to the provisions of Chapter 916, F.S., shall be sent to the Department of Children and Family Services for review and determination of an appropriate facility placement for the client. The order shall be accompanied by documentation specified in Florida Rules of Criminal Procedure 3.212 and 3.217. The complete commitment package shall be mailed to one of the following addresses:

For mentally ill forensic clients:

Forensic Admission Coordinator,
Mental Health Program Office
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(805) 487-3471

For mentally retarded forensic clients:

Mentally Retarded Defendant Program
P. O. Box 1000
Chattahoochee, FL 32324
(805) 663-7512

Upon receipt of each commitment package the department shall review the package for completeness.

(a) If complete, the date of receipt shall be recorded. The statutory 15 day period set forth in Section 916.107(1)(a), F.S., will commence on this day.

(b) If the package is incomplete the appropriate authority will be notified of the missing items, and advised that the official date of receipt of the commitment package will be delayed until all missing items are received.

(2) Clients are scheduled for admission based on date of receipt of complete commitment package. Upon notification by the department of the availability of a bed and date of assignment, the committing county will be responsible for arranging transportation.

(3) Admissions at state forensic facilities are accepted Monday through Thursday from 8:00 a.m. through 3:00 p.m., and Fridays

from 8:00 a.m. through 1:00 p.m. No weekend or holiday admissions are accepted.

(4) Assignment of a forensic client for admission to a civil mental health treatment facility shall be done according to procedures established by the department. Prior to the assignment to a civil facility, that facility must be contacted and approval obtained. A forensic client who is dangerous, or is a serious escape risk shall not be assigned to a civil facility.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107, 916.302 FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.011, Amended 11-29-12.

65E-20.012 Admission to a Forensic Facility.

(1) Forensic facilities shall admit forensic clients who are:

(a) Assigned and scheduled for admission by the appropriate Forensic Admissions Office, and

(b) Accompanied by an Order of Commitment and other documentation, as specified in Florida Rules of Criminal Procedure 3.212 and 3.217, which shall be used by facility staff in making their initial evaluation and in instituting appropriate treatment quickly.

(2) Facility staff shall review the accompanying documentation for completeness.

(3) In any case where the Order of Commitment or accompanying documentation is not complete, facility staff shall immediately notify the Forensic Admissions Office and the Facility Administrator for authorization to admit the client when appropriate.

(4) A physical examination shall be conducted on the day of arrival of the client at a forensic facility. Any apparently recent injuries noted shall be reported to the administrator of the county jail sending the forensic client. Photographs of injuries may be taken as evidence.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.13, 916.15 FS. History–New 9-29-86, Amended 7-1-96, Formerly 10E-20.012, Amended 9-29-98.

65E-20.013 Contraband Control.

(1) At the time of admission, the transporting officers shall remain with the client until the forensic facility accepts custody of the client.

(a) The transporting officers shall surrender any firearm, deadly weapon or contraband item to the facility security staff upon entering the facility grounds.

(b) The transporting officers shall transfer the client's property, including money, valuables and personal effects, to the facility staff.

(c) These provisions shall be enforced by the facility security personnel.

(2) At the time of admission, facility security staff shall examine and inventory the client's personal effects for contraband and items as determined by statute, departmental rule, or by the administrator of the facility, and designated by written institutional policy to be hazardous to the welfare of the residents or the operation of the facility. Security staff shall confiscate and appropriately dispose of such contraband, and provide the client with a receipt for the confiscated items.

(3) All employees and visitors are subject to a search of their possessions and person when on the grounds of a forensic facility. Searches of the person under this section may include inspection of the possessions carried by the person, removal of shoes, a pat-down body search, and searches by electronic methods. In any case, where a pat-down body search is authorized, such search shall be conducted by an individual of the same sex as the person searched, and all other persons present shall also be of the same sex.

(a) Employees shall be informed that their failure to allow the search to be conducted may result in disciplinary action.

(b) Visitors shall be informed that their failure to allow the search to be conducted will result in their expulsion from the facility and its grounds.

(c) All vehicles, while on the grounds of a forensic facility, are subject to search for contraband.

(4) Strip searches and cavity searches of clients in a forensic facility may be authorized by the facility administrator pursuant to written institutional policy based on the rules set forth below.

(a) Strip Searches.

1. Definition: a body search in which all clothing is removed and the entire body is visually checked, including hair, ears, mouth with dentures to be removed, armpits, hands, pubic region, between toes, soles of the feet, arms, and inner portions of legs.

2. Strip searches must be done in the area where the acts of disrobing and being searched cannot be viewed by other clients and

employees not involved in the search.

3. Staff conducting or observing the strip search shall be of the same sex as the person being searched.

4. The strip search shall be observed by another staff member who is of the same sex as the person being searched. A supervisor shall instruct the staff conducting the search as to the requirements of this policy, and shall ensure that this policy is followed.

(b) Cavity Searches.

1. Definition: a body search in which physical rather than visual inspection of bodily orifices is made. The bodily orifices include mouth, ears, nostrils, vagina and rectum.

2. Cavity searches are only to be conducted in extreme cases, where reasonable belief exists that the person has contraband upon his or her person which may be contained in a bodily orifice.

3. A cavity search will only be conducted by a physician. A registered nurse must be present continuously during the search. Either the doctor or the nurse must be of the same sex as the client being searched.

4. Cavity searches must be done in an area where the search cannot be viewed by other clients or employees not involved in the search.

5. In addition to the physician and nurse, one or more employees of the same sex as the client may be present during the search if necessary for security or to make the search possible.

(5) Searches of the client's living area may be made whenever it is deemed necessary to insure the safety and security of the facility and when there is reason to believe that contraband is present.

Rulemaking Authority 916.1093(2) FS. Law Implemented 916.107(10), 916.178 FS. History–New 9-29-86, Formerly 10E-20.013.

65E-20.014 Seclusion and Restraint for Emergency Behavior Management Purposes.

(1) General Standards.

(a) Each facility will provide a therapeutic milieu that supports a culture of recovery, individual empowerment, and responsibility. Each individual will have a voice in determining his or her treatment options. Treatment will foster trusting relationships and partnerships for safety between staff and individuals. Facility staff will be particularly sensitive to individuals with a history of trauma and use trauma informed care.

(b) The health and safety of the individual shall be the primary concern at all times.

(c) Seclusion or restraint shall be employed only in emergency situations when necessary to prevent an individual from seriously injuring self or others, and less restrictive techniques have been tried and failed, or it has been clinically determined that the danger is of such immediacy that less restrictive techniques cannot be safely applied.

(d) There is a high prevalence of past traumatic experience among individuals who receive mental health services. The response to trauma can include intense fear and helplessness, a reduced ability to cope, and an increased risk to exacerbate or develop a range of mental health and other medical conditions. The experience of being placed in seclusion or being restrained is potentially traumatizing. Seclusion and restraint practices shall be guided by the following principles of trauma-informed care: assessing trauma histories and symptoms; recognizing culture and practices that are re-traumatizing; processing the impact of a seclusion or restraint with the individual; and addressing staff training needs to improve knowledge and sensitivity.

(e) When an individual demonstrates a need for immediate medical attention in the course of an episode of seclusion or restraint, the seclusion or restraint shall be discontinued and immediate medical attention shall be obtained.

(f) Individuals will not be restrained in a prone position. Prone containment will be used only when required by the immediate situation to prevent imminent serious harm to the individual or others. To reduce the risk of positional asphyxiation, the individual will be repositioned as quickly as possible.

(g) Responders will pay close attention to the respiratory function of the individual during containment and restraint. All staff involved will observe the individual's respiration, coloring, and other possible signs of distress and immediately respond if the individual appears to be in distress. Responding to the individual's distress may include repositioning the individual, discontinuing the seclusion or restraint, or summoning medical attention.

(h) Objects shall not be placed over an individual's face. In situations where precautions need to be taken to protect staff, staff may wear protective gear.

(i) Unless necessary to prevent serious injury, an individual's hands shall not be secured behind the back during containment or restraint.

(j) The use of walking restraints is prohibited except for purposes of off-unit transportation and may only be used under direct observation of staff who have been trained for this purpose. Direct observation means that staff maintains continual visual contact of the individual and remains within close physical proximity to the individual at all times.

(k) The individual shall be released from seclusion or restraint as soon as he or she is no longer an imminent danger to self or others.

(l) Seclusion or restraint use shall not be based solely on a history of dangerous behavior or history of seclusion or restraint use. Dangerous behaviors include those behaviors that jeopardize the physical safety of oneself or others.

(m) Seclusion and restraint may not be used simultaneously for children less than 18 years of age. For adults age 18 and over, simultaneous seclusion and restraint is only permitted if the individual is continually monitored face-to-face by an assigned, trained staff member or if the individual is continually monitored by trained staff using both audio and video equipment. Staff providing this monitoring must be in close proximity to the individual.

(n) An individual who is restrained must not be located in areas subject to view by individuals other than involved staff or where exposed to potential injury by other individuals. This does not apply to individuals in walking restraints.

(o) Each facility utilizing seclusion or restraint procedures shall establish and utilize a Seclusion and Restraint Oversight Committee.

(2) Staff Training. Staff must be trained during orientation and subsequently at least annually. Prior to using seclusion or restraint, staff will demonstrate specific knowledge of or relevant competency in the following areas:

(a) Employing strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan;

(b) Using nonphysical intervention skills as well as body control and physical management techniques to ensure safety;

(c) Observing for and responding to signs of physical and psychological distress during the seclusion or restraint event;

(d) Applying restraint devices safely;

(e) Monitoring the physical and psychological well-being of the individual who is restrained or secluded, including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by facility policy associated with the one hour face-to-face evaluation;

(f) Identifying the specific behavioral changes that indicate restraint or seclusion is no longer necessary;

(g) Using first aid techniques; and

(h) Being certified in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification. The frequency of training for cardiopulmonary resuscitation will be in accordance with CPR certification requirements and facility policy.

(3) Prior to the Implementation of Seclusion or Restraint.

(a) Prior intervention shall include individualized therapeutic actions identified in a personal safety plan that address individual triggers leading to psychiatric crisis. Recommended form CF-MH 3124, Feb. 05, “Personal Safety Plan,” which is incorporated herein by reference, may be used for the purpose of guiding individualized techniques. Recommended form CF-MH 3124 may be accessed from the department’s website at "http://www.dcf.state.fl.us/mental health/laws."

(b) Prior interventions should include verbal de-escalation, calming strategies, and environmental changes to reduce identified triggers. Non physical interventions must be the first choice unless safety issues require the use of physical intervention.

(c) A personal safety plan shall be completed or updated as soon as possible after admission and filed in the individual’s medical record:

1. The personal safety plan shall be reviewed by the recovery team, and updated if necessary, after each incident of seclusion or restraint;

2. Specific intervention techniques from the personal safety plan that are offered or used prior to a seclusion or restraint event shall be documented in the individual’s medical record after each use of seclusion or restraint; and

3. All staff shall be aware of and have ready access to each individual’s personal safety plan.

(d) Contraindications to the use of specific seclusion or restraint techniques due to medical conditions will be documented in the individual’s medical record as part of the individual’s admission and subsequent physical examination or psychiatric evaluation. Staff shall be informed of any contraindications as determined by the physician or Advanced Registered Nurse Practitioner (ARNP) and shall utilize other techniques as indicated on the individual’s personal safety plan.

(4) Implementation of Seclusion or Restraint.

(a) A registered nurse or highest level staff member, as specified by written facility policy, who is immediately available and who is trained in seclusion and restraint procedures may initiate seclusion or restraint in an emergency when danger to self or others is imminent.

(b) An order for seclusion or restraint must be obtained from the physician, ARNP, or Physician's Assistant (PA), if permitted by the facility to order seclusion and restraint and stated within their professional protocol. The treating physician must be consulted as soon as possible if the seclusion or restraint was ordered by another physician.

(c) The individual must be seen face-to-face by a physician or ARNP within one hour after initiation of seclusion or restraint. The face-to-face exam may be delegated to a Registered Nurse (RN) or PA if authorized by the facility and the individual has been trained in seclusion and restraint procedures as described in subsection (2). The staff member conducting the face-to-face examination shall evaluate or review, and document the following within one hour:

1. The individual's immediate situation;

2. The individual's reaction to the intervention;

3. The individual's medical and behavioral condition;

4. The individual's medication orders, including an assessment of the need to modify such orders during the period of seclusion or restraint. If the face-to-face exam is completed by the RN or PA, the RN or PA shall consult with the physician or ARNP regarding the need to modify the resident's medication orders;

5. The need or lack of need to elevate the individual's head and torso during restraint;

6. Whether the risks associated with the use of seclusion or restraint are significantly less than not using seclusion or restraint; and

7. The need to continue or terminate the intervention.

(d) A licensed psychologist may only conduct the behavioral assessment portion of the face-to-face exam indicated in subparagraph (4)(c)3. if authorized by the facility and trained in seclusion and restraint procedures as described in subsection (2). If the face-to-face evaluation is conducted by a trained Registered Nurse or physician assistant, the attending physician who is responsible for the care of the individual must be consulted as soon as possible after the evaluation is completed.

(e) Documentation of the face-to-face examination described in subparagraphs (4)(c)1.-7., including the time and date completed, shall be included in the individual's medical record.

(f) Each written order for seclusion or restraint is limited to four hours for adults, age 18 and over; and two hours for youth age 9 through 17. A seclusion or restraint order may be renewed every two hours for youth and every four hours for adults, after consultation and review by a physician, ARNP, or PA in person, or by telephone with a Registered Nurse who has physically observed and evaluated the individual. The order may only be renewed for up to a total of 24 hours. When the order has expired after 24 hours, a physician, ARNP, or PA must see and assess the individual before seclusion or restraint can be re-ordered. The results of this assessment must be documented. Seclusion or restraint use exceeding 24 hours requires the notification of the facility administrator or designee.

(g) Once seclusion or restraint has been terminated, a new order and subsequent assessments are required to place the individual back into seclusion or restraint as indicated in subsection (4) of this rule.

(h) Each seclusion or restraint order must be signed within 24 hours of the initiation of seclusion or restraint.

(i) The seclusion or restraint order shall include the specific behavior prompting the use of seclusion or restraint, the time limit for seclusion or restraint, and the behavior necessary for the individual's release. Additionally, for restraint, the order shall contain the type of restraint ordered and the positioning of the individual, including possibly elevating the individual's head for respiratory and other medical safety considerations. Consideration shall be given to the individual's age, physical fragility, and physical disability when ordering restraint type.

(j) An order for seclusion or restraint shall not be issued as a standing order or on an as-needed basis.

(k) In order to protect all individuals served by a facility, each individual shall be searched for contraband before or immediately after being placed into seclusion or restraints.

(l) The individual shall be clothed appropriately for the current temperature and at no time shall an individual be placed in seclusion or restraint in a nude or semi-nude state.

(m) For youth under the age of 18, the facility must notify the parent(s) or legal guardian(s) of the individual who has been restrained or placed in seclusion within 24 hours after the initiation of each seclusion or restraint event. This notification must be

documented in the individual's medical record, including the date and time of notification and the name of the staff person providing the notification.

(n) Every secluded or restrained individual shall be immediately informed of the behavior that resulted in the seclusion or restraint and the behavior and the criteria necessary for release. Release criteria shall reflect that the individual is not an imminent danger to self or others.

(o) For each use of seclusion or restraint, the following information shall be documented in the individual's medical record:

1. The emergency situation resulting in the seclusion or restraint event;

2. Alternatives or other less restrictive interventions attempted, as applicable, or the clinical determination that less restrictive techniques could not be safely applied;

3. The name and title of the staff member initiating the seclusion or restraint; the date/time of initiation and release;

4. The individual's response to seclusion or restraint, including the rationale for continued use of the intervention; and

5. The individual was informed of the behavior that resulted in the seclusion or restraint and the criteria necessary for release.

(5) During Seclusion or Restraint Use.

(a) When restraint is initiated, except for walking/transport restraint, nursing staff shall see and assess the individual no later than 15 minutes after initiation and at least every hour thereafter. The assessment shall include checking the individual's circulation and respiration, including vital signs (pulse and respiratory rate at a minimum).

(b) The individual who is secluded shall be observed by trained staff every 15 minutes. At least one observation an hour will be conducted by a nurse.

(c) Restrained individuals must have continuous observation by trained staff. Documentation of the resident's condition will occur at least every 15 minutes.

(d) Monitoring the physical and psychological well-being of the individual who is secluded or restrained shall include but is not limited to: respiratory and circulatory status; signs of injury; vital signs; skin integrity; behavioral observations; verbal interactions; and any special requirements specified by facility policies. This monitoring shall be conducted by trained staff as required in subsection (2).

(e) During each period of seclusion or restraint, the individual must be offered reasonable opportunities to drink and toilet as requested. In addition, the individual who is restrained must be offered opportunities to have range of motion at least every two hours to promote comfort. Each facility shall have written policies and procedures specifying the frequency of providing drink, toileting, checking of body positioning to avoid traumatizing an individual, and retaining the individual's maximum degree of dignity and comfort during the use of bodily control and physical management techniques.

(f) Documentation of the observations and the staff person's name shall be recorded at the time the observation takes place.

(6) Release from Seclusion or Restraint and Post-Release Activities.

(a) Release from seclusion or restraint shall occur as soon as the individual no longer appears or reports to present an imminent danger to self or others. Upon release from seclusion or restraint, the individual's physical condition shall be observed, evaluated, and documented by trained staff. Documentation shall also include the name and title of the staff releasing the individual and the date and time of release.

(b) After a seclusion or restraint event, a debriefing process shall take place to decrease the likelihood of a future seclusion or restraint event for the individual and to provide support.

(c) Each facility shall develop policies to address:

1. A review of the incident with the individual who was secluded or restrained. The individual shall be given the opportunity to process the seclusion or restraint event as soon as possible but no longer than within 24 hours of release. This debriefing discussion shall take place between the individual and either the recovery team or another preferred staff member. This review shall address the incident within the framework of the individual's life history and mental health issues. It shall assess the impact of the event on the individual and help the individual identify and expand coping mechanisms to avoid the use of seclusion or restraint in the future. The discussion will include constructive coping techniques for the future. A summary of this review should be documented in the individual's medical record.

2. A review of the incident with all staff involved in the event and supervisors or administrators. This review shall be conducted as soon as possible after the event and shall address: the circumstances leading to the event; the nature of de-escalation efforts; alternatives to seclusion and restraint attempted; staff response to the incident; and ways to effectively support the individual's constructive coping in the future and avoid the need for future seclusion or restraint. The outcomes of this review should be

documented by the facility for purposes of continuous performance improvement and monitoring. The review findings will be forwarded to the Seclusion and Restraint Oversight Committee.

3. Support for other individuals served and staff, as needed, to return the unit to a therapeutic milieu.

(d) Within 2 working days after any use of seclusion or restraint, the recovery team shall meet and review the circumstances preceding the event and review the individual's recovery plan and personal safety plan to determine whether any changes are needed in order to prevent the further use of seclusion or restraint. The individual who was secluded or restrained shall be provided an opportunity to participate in this meeting. The recovery team shall also assess the impact the event had on the individual and provide any counseling, services, or treatment that may be necessary. The recovery team shall analyze the individual's clinical record for trends or patterns relating to conditions, events, or the presence of other persons immediately before or upon the onset of the behavior warranting the seclusion or restraint, and upon the individual's release from seclusion or restraint. The recovery team shall review the effectiveness of the emergency intervention and develop more appropriate therapeutic interventions. Documentation of this review shall be placed in the individual's clinical record.

(e) If an individual has had multiple seclusion or restraint events, the recovery team shall conduct a thorough clinical review, including a medication review, to determine if any changes to the recovery plan or overall treatment and services are needed.

(f) The Seclusion and Restraint Oversight Committee shall conduct at least weekly reviews of each use of seclusion and restraint event. The Committee shall also monitor patterns of use, for the purpose of ensuring least restrictive approaches are utilized, to prevent or reduce the frequency and duration of use.

(7) Reporting.

(a) All civil and forensic state mental health treatment facilities serving individuals committed pursuant to Chapter 916, F.S., are required to report each seclusion and restraint event to the Department of Children and Families. This reporting shall be done electronically using the Department's web-based application, either directly via the data input screens, or indirectly via the File Transfer Protocol batch process. The required reporting elements include: provider tax identification number; individual's social security number and identification number; date and time the seclusion or restraint event was initiated; discipline of the individual ordering the seclusion or restraint; discipline of the individual implementing the seclusion or restraint; reason seclusion or restraint was initiated; type of restraint used; whether significant injuries were sustained by the individual; and date and time seclusion or restraint was terminated. Facilities shall report seclusion and restraint events to the Department on a monthly basis. Events that result in death or significant injury, either to a staff member or individual, shall be reported to the department's web-based system as required by the department. The purpose of collecting protected health information, such as social security number, is to uniquely identify each person served for treatment, payment, and health care operation as authorized by the HIPAA privacy and security standards, as referenced in 45 CFR 164.506.

(b) All facilities that are subject to the Conditions of Participation for Hospitals, 42 Code of Federal Regulations, part 482, under the Centers for Medicare and Medicaid Services (CMS), must report to CMS any death that occurs in the following circumstances:

1. While an individual is restrained or secluded;

2. Within 24 hours after release from seclusion or restraint; or

3. Within one week after seclusion or restraint, where it is reasonable to assume that use of the seclusion or restraint contributed directly or indirectly to the individual's death.

Each death described in paragraph (7)(b) shall be reported to CMS by telephone no later than the close of business the next business day following knowledge of the individuals' death. A report shall simultaneously be submitted to the Director of Mental Health/Designee in the Mental Health Program Office Headquarters in Tallahassee, FL. The address is: 1317 Winewood Blvd., Tallahassee, FL 32399-0700. Facilities that are not required to report these deaths to CMS shall report the death to the Director of Mental Health/Designee in the Mental Health Program Office Headquarters at the address above.

(c) The Department shall collect and review the data on a monthly basis. The Director of Mental Health shall be informed of any deaths or significant injuries related to seclusion or restraint, and significant trends regarding seclusion and restraint use.

(8) Nothing herein shall affect the ability of emergency medical technicians, paramedics or physicians, or any person acting under the direct medical supervision of a physician to provide examination or treatment of incapacitated individuals in accordance with Section 401.445, F.S.

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