

RESPITE WORKGROUP MEETING NOTES

January 4, 2016

Regular text = paraphrased discussion

Italics=Department's response

Bold, italics, and indented=rule with changes highlighted

In addition to comments made at the January 4, 2016 meeting, these Notes also address comments the Department has received outside the meeting about the draft rules for Respite.

R9-10-707(E)(1)(a)

A comment was made that “allowing the exemption of a physical exam of a child based upon the anticipated (short) length of stay removes a potential opportunity to discover bruising and other injuries or aspects that could be indicative of abuse and neglect.”

Laws 2015, Ch. 158, under which this rulemaking is being carried out, states that in “adopting the rules, the director shall ... [a]llow children who are receiving behavioral health services to receive respite care in a behavioral health residential facility without a nursing assessment or physical examination if the child will be receiving respite services for fewer than five consecutive days at the facility.” The Department does not plan to make a change to the rule.

R9-10-1025 New (C)

During a discussion of the Meeting Notes from the November 16, 2015 meeting, a question was asked about whether a parent needs to provide permission for a particular activity on a particular day. A comment was made that one facility providing respite services in the community has a list of possible activities on its website, and parents give permission for the facility to take a child as part of the intake process.

Parental permission may cover multiple days for the same event (i.e., going to the movies every Thursday at 2:00), but it must list the activity, the date or dates of the activity, etc., as specified in the rule. A blanket permission to take the child for any activity provided does not meet the rule requirements.

A question was asked about whether written permission is required for all outings or only those for children.

The authority under which this rulemaking is being conducted is specific to respite for children. Therefore, this rulemaking only addresses written permission for children receiving respite services.

R9-10-1025(C)(12)

A comment was made that the rule does not go far enough in defining staffing ratios, and that the Department should add language that mandates staffing that is in accordance with a child’s Individualized Service Plan (ISP).

A rule is required to have general applicability, and not every child receiving respite services may have an ISP. The applicable elements of an ISP should be included in the behavioral health assessment required for the child or in another part of the child’s medical record. The facility is still required to provide, under R9-10-1006, sufficient personnel members with the qualifications, skills, and knowledge necessary to provide the services in the outpatient treatment center’s scope of services, meet the needs of a patient, and ensure the health and safety of a patient. If a specific payor has additional requirements, those requirements could be included in the contract with the outpatient treatment center providing respite services on the premises. The Department does not plan to make a change to the rule.

R9-10-1025(E)(13)

During a discussion of the Meeting Notes from the November 16, 2015 meeting, a comment was made that children leave at the end of the day with whatever they brought with them. A child’s soiled clothing is not cleaned by the outpatient treatment center but is sent home with the child. A comment was made that the rule should be clarified to reflect this situation.

The Department plans to change the rule as follows to clarify that the requirement in R9-10-1025(E)(13) does not apply to clothing provided for a child by the child’s parents:

E. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that in each area designated for providing respite services:

13. Each child's toothbrush, comb, washcloth, and cloth towel, ~~and clothing that are provided for the child's use by the child's parent~~ are ~~is~~ maintained in a clean condition and stored in an identified space separate from those of other children;

The Department acknowledges that a child who does not wear diapers may have soiled clothing. To clarify that soiled clothing is sent home with a child, the Department plans to move requirements related to soiled clothing out of subsection (H) and change the rule by adding the following in subsection (F):

F. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that a personnel member:

4. Empties clothing soiled with feces into a flush toilet without rinsing;

5. Places a child's soiled clothing in a plastic bag labeled with the child's name, stores the clothing in a container used for this purpose, and sends the clothing home with the child's parent;

R9-10-1025(F)(5)

A question was asked during the November 16, 2015 meeting about why so many activities are listed in the rules. The comment was made that there are activity requirements for a child set by each payor and that a licensed behavioral health professional is monitoring all behavioral health services provided by the outpatient treatment center. Stakeholders were asked to provide online comments stating those activities that are most important. No comments were received by the Department, so no changes were made to the subsection. The list of activities was discussed during the January 4 meeting.

Based on the discussion at the January 4 meeting, the Department plans to change the rule as follows:

F. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that a personnel member:

5. Provides activities and opportunities, consistent with a child's behavioral health assessment, for each child to:

a. Gain a positive self-concept;

b. Develop and practice social skills;

e. Think, reason, question, and experiment;

c. Acquire language communication skills;

e. Develop physical coordination skills;

d. Participate in structured large muscle physical activity;

e. Develop habits that meet health, safety, and nutritional needs;

f. Express creativity;

g. Learn to respect cultural diversity of children and staff;

h. Learn self-help skills; and

i. Develop a sense of responsibility and independence;

R9-10-1025(F)(8)

A question was asked during the November 16, 2015 meeting about how the list of toys and equipment was derived. The comment was made that they may not be appropriate for every group of children receiving respite services. Stakeholders were asked to provide online comments stating those toys, materials, and equipment that would be more appropriate, but no comments were received. During the January 4 meeting, a question was asked about whether more general categories of toys, materials, and equipment.

The Department plans to change the rule as follows, including the change already documented in the Meeting Notes of the November 16, 2015 meeting:

F. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that a personnel member:

8. Ensures that each indoor area has a supply of age-appropriate toys, materials, and equipment, necessary to implement the daily activity schedule required in subsection (F)(4), which are too large for a child to swallow and free from sharp edges and points, in a quantity sufficient to meet the

needs for the number of the children receiving respite services at the outpatient treatment center, including:

- a. Arts and crafts supplies;**
- b. Books;**
- c. Rubber or soft plastic balls Balls;**
- d. Puzzles, blocks, and toys to enhance manipulative skills;**
- e. Blocks;**
- e. Washable soft Creative play toys and dolls;**
- f. Musical instruments; and**
- g. Indoor and outdoor equipment to enhance large muscle development;**

R9-10-1025(F)(9)

During a discussion of the Meeting Notes from the November 16, 2015 meeting, a comment was made that the Joint Commission, which accredits some of the outpatient treatment centers, considers sunscreen and other such products as medications. A concern was expressed that some facilities do not want to be perceived by the Joint Commission as providing medications.

In this setting, the Department does not consider the application of personal products, such as those listed, as the administration of medication because a child receiving respite services on the premises of an outpatient treatment center is not there due to a need to have the personal products applied as treatment. To better clarify that a parent must provide the personal product for use on the child and give permission for its use, the Department plans to clarify the rule as follows:

- 9. Does the following when a parent permits or asks a personnel member to apply personal products, such as petroleum jelly, diaper rash ointments, sun screen or sun block preparations, toothpaste, and baby diapering preparations on the parent's child:**
 - a. Obtains the child's personal products from the child's parent or, if the administrator provides the personal products for use by the a child, obtains and written approval for use of the personal products from the child's parent;**
 - b. Labels the child's personal products with the child's name; and**
 - c. Keeps the child's personal products inaccessible to children; and**

R9-10-1025(I), (J), and (K)

During a discussion of the Meeting Notes from the November 16, 2015 meeting, a comment was made that the rules do not address brown-bag lunches. Some facilities might not be providing food because parents might send food with a child.

Another comment was made that two snacks and one or more meals for a child on the premises for more than eight hours is unclear and should be two snacks and two or more meals.

The Department plans to clarify that a facility may obtain a brown-bag lunch or other food for a child from the child's parent, rather than providing the food for the child. However, if a parent does not provide sufficient food to meet the meal/snack frequency required in rule, the outpatient treatment center will be required to supplement the food provided by a parent, and to ensure that the supplemented food complies with the content of the meals/snacks in Table 10.1. The meal/snack frequency needs to be read in conjunction with the hours during which meals must be provided. Since a child may arrive at 8:30 or 9 a.m. and stay until 5 or 6 p.m., thus receiving respite services for more than eight hours, but only be served a morning snack, lunch, and an afternoon snack, the meal/snack frequency in the draft rules is correct. However, a child may also arrive at 7:30 a.m., stay until 3:30, thus receiving respite services for four to eight hours, and have breakfast, a morning snack, lunch, and an afternoon snack. To consolidate the requirements now in subsections (I), (J), and (K) and to clarify food requirements, the Department plans to change the rules as follows:

- I. Except as provided in subsection (J), an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:**
 - I. Serve the following meals or snacks to a child receiving respite services on the premises for the following periods of time:**
 - a. Two to four hours, one or more snacks;**
 - b. Four to eight hours, one or more snacks and one or more meals;**

- c. *More than eight hours, two snacks and one or more meals; and*
- d. *During any of the meal times in subsections (I)(2) through (4), the specified meal;*
- 2. *Make breakfast available to a child receiving respite services on the premises before 8:00 a.m.;*
- 3. *Serve lunch to a child who is receiving respite services on the premises between 11:00 a.m. through 1:00 p.m.;*
- 4. *Serve dinner to a child who is receiving respite services on the premises from 5:00 p.m. through 7:00 p.m. and who will remain on the premises after 7:00 p.m.;*
- 5. *Ensure that a meal or snack provided by the outpatient treatment center meets the meal pattern requirements in Table 10.1; and*
- 6. *If the outpatient treatment center provides a meal or snack to a child:*
 - a. *Make a second serving of a food component of a provided snack or meal available to a child who requests a second serving, and*
 - b. *Substitute a food that is equivalent to a specific food component if a requested second serving of a specific food component is not available.*
- J. *An administrator of an outpatient treatment center that is authorized to provide respite services to children on the premises:*
 - 1. *May serve food provided for a child by the child's parent;*
 - 2. *If a child's parent does not provide a sufficient number of meals or snacks to meet the requirements in subsection (I)(1), shall supplement, according to the requirements in in Table 10.1, the meals or snacks provided by the child's parent; and*
 - 3. *If applicable, shall serve food for a child at the times and in quantities consistent with the information documented according to subsection (C)(9)(f) for the child and the child's behavioral health assessment, to meet the child's dietary and nutritional needs.*

Table 10.1

During a discussion of the Meeting Notes from the November 16, 2015 meeting, a question was asked about whether a facility has to document the food that a child eats or doesn't eat.

The current draft requirements for respite do not require that a facility document the food that a child eats, only the food that was made available to the child. However, if the child's behavioral health assessment or, if applicable, medical condition requires such documentation because the food that the child eats or doesn't eat affects the child's behavioral health or physical health, the facility may be required under R9-10-1009(C) to document such information.

R9-10-1025(O) New (P)

During a discussion of the Meeting Notes from the November 16, 2015 meeting, a question was asked about the use of an emergency safety response in outpatient treatment centers providing respite services on the premises. An emergency safety response does not seem to be allowed in outpatient treatment centers.

In no area of an outpatient treatment center, other than the area of the outpatient treatment center authorized for the provision of respite services to children on the premises, is an emergency safety response allowed to be used. This is consistent with the limitation on the use of restraint or seclusion to that area of an outpatient treatment center authorized to provide behavioral health observation/stabilization services. The Department does not plan to make a change to the rule.

R9-10-1025(O)(2)(a)(i)

A concern was expressed that a child's behavioral health assessment will not contain the most current guidelines and limitations set forth in the child's ISP that is developed by the child's Child and Family Team.

Not every child receiving respite services may have such an ISP. If a specific payor has additional requirements, those requirements could be included in the contract with the outpatient treatment center providing respite services on the premises. The Department does not plan to make a change to the rule.

R9-10-1025(O)(2)(b)(i)

A concern was expressed that staff in an outpatient setting may have less knowledge and practical experience with using emergency safety responses than staff in inpatient and residential settings. The comment was also made that the draft rule language "fails to take into consideration the agreed-upon methods and techniques that are more

clearly customized to each child in their respective Crisis Plan and Individualized Service Plan that are developed through the Child and Family Team (CFT) processes.”

Not every child receiving respite services may have a Crisis Plan or an ISP. If a specific payor has additional requirements, those requirements could be included in the contract with the outpatient treatment center providing respite services on the premises. The Department believes that the requirements for use of an emergency safety response in the current draft rules are sufficient to protect the health and safety of a child receiving respite services. The Department does not plan to make a change to the rule.

R9-10-1025(O)(2)(c), (d), and (e)

A comment was made that the use of an emergency safety response should be documented before a personnel member’s shift ends, rather than “within 24 hours” to ensure that staff coming in after the shift can read about the incident and that details are not forgotten. Another comment was received that 10 working days for a behavioral health professional to review the use of the emergency safety response is too long. A third comment was made that the staff responsible for entering the findings of the review of the use of the emergency safety response into the child’s medical record should be the behavioral health professional.

As stated in the Meeting Notes from the November 16, 2015 meeting, the Department does not plan to make a change to time-frame requirements for documenting the use of an emergency safety response or reviewing its use. The Department plans to change the rule to require that a child’s parent is notified of the use of an emergency safety response and that the notification of a child’s parent is documented. The Department also plans to change the rule to require a behavioral health professional to document the review of use of the emergency safety response. The rule will read as follows:

- P. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises:**
- 1. May allow a personnel member to separate a child who is receiving respite services on the premises from other children for unacceptable behavior for no longer than three minutes after the child has regained self-control, but not more than 10 minutes without the personnel member interacting with the child, consistent with the child's behavioral health assessment;**
 - 2. Shall ensure that:**
 - a. A personnel member, consistent with a child's behavioral health assessment:**
 - i. Defines and maintains consistent and reasonable guidelines and limitations for the child’s behavior;**
 - ii. Teaches, models, and encourages orderly conduct, personal control, and age-appropriate behavior; and**
 - iii. Explains to the child why a particular behavior is not allowed, suggests an alternative, and assists the child to become engaged in an alternative activity;**
 - b. An emergency safety response is:**
 - i. Only used:**
 - (1) By a personnel member trained according to R9-10-716(F)(1) to use an emergency safety response,**
 - (2) For the management of a child’s violent or self-destructive behavior, and**
 - (3) When less restrictive interventions have been determined to be ineffective; and**
 - ii. Discontinued at the earliest possible time, but no longer than five minutes after the emergency safety response is initiated;**
 - c. If an emergency safety response was used on a child, a personnel member, when the child is discharged to the child’s parent:**
 - i. Notifies the child’s parent of the use of the emergency safety response on the child and the personnel member or child behavior, event, or environmental factor that caused the need for the emergency safety response; and**
 - ii. Documents in the child’s medical record that the child’s parent was notified of the use of the emergency safety response;**
 - d. Within 24 hours after an emergency safety response is used for a child receiving respite services on the premises, the following information is entered into the child's medical record:**
 - i. The date and time the emergency safety response was used;**

- ii. The name of each personnel member who used an emergency safety response;
- iii. The specific emergency safety response used;
- iv. The personnel member or child behavior, event, or environmental factor that caused the need for the emergency safety response; and
- v. Any injury that resulted from the use of the emergency safety response;
- e. Within 10 working days after an emergency safety response is used for a child receiving respite services on the premises, a behavioral health professional reviews the information in subsection (P)(2)(d) and documents the review;

R9-10-1025(CC) New (EE)

During a discussion of the Meeting Notes from the November 16, 2015 meeting, a question was asked about the requirement for a fire extinguisher in a kitchen, since some facilities may not have a kitchen.

An outpatient treatment center that has a refrigerator to store lunches provided by a parent and a microwave to warm up the food may be considered to have a kitchen. To make the rule more consistent with requirements for other health care institutions, the Department plans to change the rule as follows:

CC. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall install and maintain a portable, pressurized fire extinguisher that meets, at a minimum, a 2A-10-BC rating of the Underwriters Laboratories in an outpatient treatment center's kitchen and any other location required for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, by Standard 10-1 of the International Fire Code, incorporated by reference in A.A.C. R9-1-412.