

# CHAPTER 10 – ARTICLE 2

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**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 68.99.84.80**Response Started:** Sunday, May 5, 2013 7:57:46 PM**Response Modified:** Sunday, May 5, 2013 8:00:06 PM**1. What parts of the draft rules do you believe are effective?**

Please note that the Office of Human Rights (OHR) is the unit of Arizona Department of Health Services/Division of Behavioral Health Services that provides advocacy to individuals with a Serious Mental Illness (SMI) in Arizona's public behavioral health system. To further our mission – providing advocacy to individuals with a SMI to help them understand, protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services in the public behavioral system in Arizona – OHR reviews and submits comments on proposed changes to rules, regulations, policies, etc. that affect individuals with a SMI. R9-10-210 emphasizes the need to address whether a person is under a guardianship during the assessment and that is absolutely crucial to ensure informed and general consent during the person's admission and stay. R9-10-211 A contain important requirements about involvement of the person and any representative in discharge. R9-10-224.18 A specifies that seclusion room cannot be the patient's bedroom or sleeping area – this is important as some facilities have been found using the same room to seclude the patient as their "temporary" bedroom or place to sleep.

**2. How can the draft rules be improved?**

In general, the use of the word "patient" is not preferred to "client" or even "person" or "individual." Rights R9-10-209 covers individual rights but it fails to make a reference to sharing information on SMI rights and specifically R9-21-101, et seq. with individuals who are identified as SMI. This section also omits a significant number of rights that is contained in the current licensure rules – which should not be omitted. We are shocked to see that subsection B 1 a permits the "intentional infliction of physical, mental or emotional pain" that is related to the "patient's condition." How can this be? We strongly support removal of the qualifier about relation to the individual's condition. We also strongly suggest that a section noting the word "abuse" is also inserted – as that would cover instances of negligence that would not fall under "intentional." In the same subsection under f & g, we note concern that the term "sexual abuse" is used and then two references to Arizona criminal law are made – is this sufficient to cover such, as not all acts may fall under a criminal definition yet still should be prohibited. With respect to seclusion or restraint in subsection h, the standard noted is not the same as other parts of the draft rules indicate, so we suggest removing that and staying with the original language that refers to coercion, convenience, retaliation, etc. Additionally, subsection C.4 is missing a reference to access to telephone to make and receive telephone calls. Psychiatric Services R9-10-224 makes references to a person being inpatient as "an inpatient" – which is even more of a label than "patient" is. As noted above, we suggest the term individual or person or client – with any qualifying language like "who is inpatient" or "admitted to the inpatient unit." R9-10-224.6 f should mention in relation to establishing policies and procedures on seclusion and restraint that they must be consistent and comply with all existing laws – this will ensure they meet all state and federal requirements. R9-10-224 subsection 8 discusses if the hospital uses "time out" and we strongly support making it much clearer in this subsection that time out should end when the individual says it does – as it is purely a voluntary process. The current details do not make it clear and make it seem more as if the staff drives when and how long a time out session is. R9-10-224 subsection 9 addresses use of seclusion or restraint. Please note that OHR has extensive experience with seclusion/restraint issues as we regularly review all reports involving seclusion/restraint for individuals with a SMI and address issues often directly with the facilities using seclusion/restraint. We strongly believe this subsection should make some reference to the requirement that use of seclusion or restraint must be consistent with/comply with existing laws on seclusion and restraint. Subsection 9 (& 10) delineate when seclusion or restraint can be used and unfortunately, has broadened the circumstances per the current rules. The current rules require in an "emergency safety situation" which is also clearly defined currently. However the draft rules note two instances in which seclusion or restraint can be used: 1) in an emergency situation, 2) for management of patient's violent or self-destructive behavior – when less restrictive alternatives have been determined ineffective and for the purpose of ensuring the "immediate physical safety of the patient or to stop physical harm to another individual." Unfortunately, "emergency situation" is not defined anywhere in the rules so it is unclear what this entails. The general section definitions subsection defines an "emergency" but not an "emergency situation." The use of the term "patient's violent" behavior is problematic as it is also undefined and open to varying interpretations. We

strongly support continuing the use of the term and definition of "emergency safety situation" and its definition; or in the alternative, that the term "in an emergency" be used only to limit confusion and differing interpretations. Additionally, the purpose (subsection 3 b iv) should also include "preventing imminent harm to another individual" to cover instances where the person who is engaged in an action, such as rushing toward another individual on the unit with a chair ready to strike the person, the staff can intervene with physical restraint action (assuming all lesser interventions fail) before physical harm actually starts. As it stands now, the staff would have to allow the individual to strike the other person first before using a physical restraint. If in subsection 9 c the seclusion or restraint must be discontinued at the earliest possible time, then what other criteria would be needed to be specified as subsection 12.e requires. The release criteria are simply that when the emergency has passed, the person should be released! We suggest either removing this subsection or re-emphasizing within it that the specific criteria are meant to help staff determine when the emergency has subsided. Similarly, subsection 16 a v mentions "clinical identification of specific behavioral changes that indicate seclusion or restraint is no longer necessary" should be tied to when the emergency has passed – that is when seclusion/restraint must be discontinued. Subsection 17. a would also be clearer if include that according to policies and procedures and "existing laws" related to seclusion or restraint. Similarly, subsection 17 d should contain a reference to "existing laws" as there are significant state and federal requirements with respect to monitoring. Additionally, 15 minute checks including documentation of what the individual is doing at the time should be specifically required for any seclusion or restraint lasting 15 minutes or longer as is currently required – otherwise there is no way to ensure the individual's safety as the time in seclusion/restraint gets longer (often increasing chance for safety and/or medical issues to arise) or to review whether a seclusion or restraint was still justified as time passes. Subsection 17 f makes another reference to discontinuing "at the earliest possible time" – again we suggest making this more consistent with previous language and tying it to the emergency being over or subsiding to make it consistent/clearer. Medical Records Subsection C of R9-10-229 should note a requirement that when a resident has a representative, proof of the legal authority of the representative must also be stored in the records. This makes it clear who holds the power to give consent and also supports appropriate communication with the representative

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### **3. Has anything been left out that should be in the rules?**

Hospitals will inevitably provide medication services but no reference is made to the inpatient facility coordinating medication/knowledge of current medication prescribed with any outpatient service provider already in place and/or primary care provider or other provider who has prescribed medication to the individual. This addition would be beneficial to individuals who go inpatient to ensure stronger coordination of prescribed medications

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**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 71.223.19.154**Response Started:** Sunday, May 5, 2013 6:46:33 PM**Response Modified:** Sunday, May 5, 2013 7:40:14 PM**1. What parts of the draft rules do you believe are effective?**

Thank you for your work on the hospital rules, the Arizona Hospital and Healthcare Association has a few suggested revisions below

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**2. How can the draft rules be improved?**

Throughout the hospital rules, please consider changing "ensure" back to "require" R9-10-201 - "special hospital" - please clarify what is meant by "age" in b or remove it. Some facilities treat geriatric psych patients, but admission is based on the condition or diagnosis and not necessarily the age of the patient. For example, an Alzheimer's patient would be considered geropsych, but an individual could have an early onset of Alzheimer's in their late 40's which makes limiting admission according to age problematic. R9-10-203 - why does a governing authority need to approve policies and procedures? This is often a responsibility of the administrator who is hired by the governing authority. Please add flexibility for governing authorities to delegate this responsibility to the administrator. R9-10-209 (C)(1) - please remove "source of payment". Hospitals often do admit or deny treatment based on a person's insurance status for elective procedures. R9-10-210 (3) - informed consent doesn't always take place before or at time of admission, it can take place after admission once treatment has begun. Please revise. R9-10-224 (2) - please add "providing psychiatric services" after "special hospital" so it reads: An inpatient admitted to an organized psychiatric services unit or special hospital providing psychiatric services. R9-10-224 (4) - this sentence is hard to read, please separate the two actions out into 2 different numbers so it reads: 4. An individual is not admitted to an organized psychiatric services unit or special hospital if the individual's medical needs cannot be met while the individual is an inpatient admitted to the organized psychiatric services unit or special hospital. 5. An individual is transferred out of the special hospital or organized psychiatric services unit if the individual's medical needs cannot be met while the individual is admitted to the special hospital or the organized psychiatric services unit. - In the current R9-10-224(5) - add "in an emergency situation" after "chemical restraint" so it reads: Except for a psychotropic drug used as a chemical restraint in an emergency situation. R9-10-224 (6)(f)(iii)(4) - please substitute "adjusted for tightness" for "loosened". Loosened could be a safety hazard, but the restraints are checked to make sure they are not too tight. R9-10-224 (7)(a) - please clarify what is meant by "dies". Does it mean at the facility? a person could die after they have been transferred to another facility. (b) please revert to the old reporting requirements of having a verbal notification to ADHS within 24 hours and a written notification within 5 working days. R9-10-224 (10) - please revise so that restraint or seclusion can be applied when a patient or another individual is in "imminent danger of being physically harmed" rather than is "being physically harmed". R9-10-224 (16)(a)(vii) - please remove medical staff members from the requirement demonstrate the techniques. R9-10-224 (17)(c) - this is where the definition of "available" becomes problematic since the physician or nurse may not be "immediately" available. "Immediately" is used in the definition of "available". R9-10-224 (20) - please change "order is renewed" to "a new order is obtained". Orders are not renewed - new ones are issued. R9-10-230 (5) - Please change the TB testing requirements to 24 months for personnel rather than 12 months

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**3. Has anything been left out that should be in the rules?**

No



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**Respondent Type:** Normal Response**Collector:** Web Link (Web Link)**Custom Value:** empty**IP Address:** 24.251.153.14**Response Started:** Sunday, May 5, 2013 2:04:46 PM**Response Modified:** Sunday, May 5, 2013 2:08:39 PM**1. What parts of the draft rules do you believe are effective?**R9-10-231 Dietary Services

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**2. How can the draft rules be improved?**

This section refers to dietary needs to be met. The foundation for this to be met is a Menu that meets their nutritional needs as reviewed by a registered dietitian (RD) Other agencies have this in their regulations and it would be more consistent for this to read in Hospitals as well

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**3. Has anything been left out that should be in the rules?**

4. A registered dietitian is employed full-time, part-time, or as a consultant to a. Reviews a food menu before the food menu is used to ensure that patient's nutritional needs are being met, b Documents the review of a food menu, and c Is available for consultation regarding a resident's nutritional needs;

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## Article 2. Hospitals

1. 202C. Submitting the accreditation report is optional
2. 203A4 **Boards do not approve hospital policies.** We agreed on language in current rules
3. 203C.2.b Establish policies that "Cover the provision of hospital services" What does that mean?
4. REMOVED 204B4b—"Except for information or documents that are confidential under federal or state law, provided to the Department. ADHS is not entitled to information protected in accordance with ARS 36 445 et seq. Removing this language from the regulations will not entitle ADHS to obtain it.
5. 207B.1 Med staff must provide evidence of freedom from TB per 10-112 NO
6. 208C2 Hospitals cannot "ensure" the implementation of the acuity policy, which is why ADHS adopted a policy statement to address those instances
7. 209B 2 e Standard process to photograph patient at time of service to prevent fraud Why is consent required?
8. 209.C. Cannot discriminate based on source of payment. Does that mean we can't refuse elective care if the patient is not insured or not with a contracted insurer? Right to receive treatment—does that mean we can't refuse if not indicated or futile?
9. 210 3&4. "Informed consent" is not obtained at time of admission. Informed consent is required for surgery, psychotropic medications, not for admission
10. 210 6 Add Or within 48 hours
11. 211 A Add "if applicable" to end of first line
12. 211 B 3&4. Old rule: Except if discharged to a location other than another hospital. Discharge instructions are not given if transferred to another hospital
13. 213A 2 As medical records are now electronic, will not accompany the patient during transfer
14. 224 6.f ii Ongoing training for medical staff members who have direct patient contact while in restraint. WHY?????
15. 224 9.v **Restraint to "stop physical harm to another"** Does that mean that harm must have started? Why not to "prevent" harm?
16. 224 10 **NO.** Initiate without an order only when patient or another is being physically harmed. So when a patient is about to harm himself or someone else, we need to wait for harm????? And we can't ensure that the order will be obtained while the restraints are being applied. (new)
17. 224 16 Med staff member cannot monitor a patient during restraint without training. Why not?
18. 224 17 c. The physician or nurse practitioner who ordered the restraint or seclusion is available for consultation throughout the duration of the restraint. The LIP may be seeing other patients. Not immediately available
19. 229 A3a Outpatient treatment orders are not timed, ie mammogram order
20. 230A 5 TB—inconsistent with other rules. This is old language we agreed upon