May 15, 2000

H 1520. RESTRAINTS IN FACILITIES (=S 1221). *TO REGULATE THE USE OF RESTRAINTS, SECLUSION, AND OTHER PROCEDURES IN CERTAIN FACILITIES, TO REQUIRE REPORTING OF DEATHS IN CERTAIN FACILITIES AND IMPOSING PENALTIES FOR FAILURE TO REPORT, AND TO AUTHORIZE THE GOVERNOR'S ADVOCACY COUNCIL FOR PERSONS WITH DISABILITIES TO HAVE ACCESS TO INFORMATION ABOUT THE DEATHS.* Identical to S 1221, introduced 5/15/00.

Intro. by Insko, Crawford, Goodwin, Alexander, Cansler, Earle, and Nye.

Ref. to Slct Health Care	GS 122C, 131D

June 21, 2000

H 1520. RESTRAINTS IN FACILITIES. Intro. 5/15/00. House committee substitute makes the following changes to 1st edition. Removes penalties for failure to report. Removes proposed statutory amendments, in GS Ch. 122C, of standards for when a facility (for the mentally ill, the developmentally disabled, and substance abusers) may use various kinds of restraints. Also removes definitions of these specific kinds of restraint, like “isolation time-out” and “planned restrictive intervention.” Requires that facilities implement policies and practices that emphasize use of alternatives to physical restraint and seclusion and provides that these options may be used only by trained staff, whose skills are tested annually. Retains requirement that Comm’n for Mental Health, Developmental Disabilities, and Substance Abuse Services adopt rules to implement revisions to GS 122C-60 (use of physical restraints or seclusion). Retains provision that a facility using physical restraint or seclusion must collect data on their use, analyze the data to monitor its effectiveness, and take corrective action where necessary. Requires that facilities make that data available to the Secretary of the Dep’t of Health and Human Services. Makes clear that section does not abrogate legal requirements about confidentiality, privilege, or other prohibitions against disclosure of information provided to the Secretary.

Rewrites new GS 131D-10.5A to require that residential childcare facilities collect data on the use of restraints, monitor effectiveness, and take corrective action as necessary. Revises proposed GS 122C-31 (report of client death) to provide that a facility must report immediately about the death of a client that occurs within seven days of physical restraint or seclusion of the client (in prior version, all deaths were to be reported). Adds similar requirements in new GS 131D-34.1 for adult care homes. Adds requirement that Secretary report annually on October 1 to the Legislative Study Comm’n on Mental Health, Developmental Disabilities, and Substance Abuse Services about facility compliance with restraint standards, reports of deaths, and follow-up investigations.

June 22, 2000

H 1520. RESTRAINTS IN FACILITIES. Intro. 5/15/00. House amendment makes the following changes to 2nd edition. Amends GS 122C-31 to require correctional facilities to notify the Secretary of the Dep’t of Corrections within three days of the death of any client that results from violence, accident, suicide, or homicide. Amends GS 131D-10.6B and 131D-34.1 accordingly to require notice to the Dep’t of Health and Human Services of deaths of residents in foster care and adult care homes client that results from violence, accident, suicide, or homicide.

June 26, 2000

H 1520. RESTRAINTS IN FACILITIES. Intro. 5/15/00. [Correction] House amendment of 6/22 makes the following changes to 2nd edition. Amends GS 122C-31 to require correctional facilities to notify the Secretary of the Dep’t of Health and Human Services within three days of the death of any client that results from violence, accident, suicide, or homicide. Amends GS 131D-10.6B and 131D-34.1 accordingly to require notice to the Dep’t of Health and Human Services of deaths of residents in foster care and adult care homes client that results from violence, accident, suicide, or homicide.

June 28, 2000

H 1520. RESTRAINTS IN FACILITIES. Intro. 5/11/00. Senate committee substitute makes the following changes to 3rd edition. Changes title to “PERTAINING TO THE USE OF RESTRAINTS AND SECLUSION IN CERTAIN FACILITIES, REQUIRING THE REPORTING OF CERTAIN DEATHS IN CERTAIN FACILITIES, AND IMPOSING A PENALTY FOR FAILURE TO REPORT.” Amends GS 122C-31, GS 131D-10.6B, and GS 131D-34.1 to provide that if a facility fails to report a death within the time limits required by these statutes, Dep’t of Health and Human services may assess a civil penalty against the facility of not less than $500 or more than $1,000.