May 15, 2000

S 1221. RESTRAINTS IN FACILITIES (=H 1520). *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 DEATHS.* Rewrites GS 122C to regulate the use of restraints and seclusion in facilities for the mentally ill, the developmentally disabled, and substance abusers. Amends client rights provisions to specify that methods of physical restraint or seclusion may only be used when there is imminent danger of harm to the client or others, or when part of planned restrictive intervention. Planned restrictive intervention may only be used when 1) there is documented evidence that serious harm to client or others will occur if restraint is not used; 2) the restrictive intervention is used only as a last resort after other less restrictive alternatives have failed; 3) the intervention has been approved by a physician or psychologist prior to implementation by a treatment planning team; 4) the client or the client's legally responsible person has consented to the plan in writing; and 5) the plan for use of restrictive intervention will expire 90 days after its initial adoption unless review finds continued implementation is required. Facilities must end restraint or seclusion when client is no longer a danger to self or others. In all cases, the facility must use the least restrictive form of restrain or seclusion, and must obtain the written order of a physician or psychologist within one hour of initiating restraint or seclusion. A facility must ensure that a client is continuously observed while under restraint or in seclusion, and must ensure that client is conscious, breathing freely, free from pain, and verbally responsive, and in motor control during all restraint and seclusion. Facilities must develop procedures to implement requirements of act and must document each instance of the use of restraint or seclusion in a client's record. Facility also must keep and analyze data on the use of restraint and seclusion in the facility. Rules also apply to individuals or entities that provide services to individuals who receive services from a facility, who charge a fee for the services, and who are not licensed under 122C. Requires that the Comm'n for Mental Health, Developmental Disabilities, and Substance Abuse Services adopt rules to implement the act that must address external review of use of planned restrictive interventions on a regular basis, staff training and competence, establishment of time frames for renewal of restraint orders, and collection and analysis of data from facilities on the use of restraint and seclusion. Amends GS 131D-10.5A to provide that physical restraint may be employed in a residential child-care facility only when there is imminent risk of harm to the child or others. Physical restraint can be employed only by trained and competent staff and the child must be observed continuously while restrained. Facility must document all use of restraint and Comm'n must adopt rules to implement the requirements. Amends GS 131D-2 to impose similar restrictions on adult care homes for the aged and disabled. Restraints may be used in adult care homes when the resident has medical symptoms that warrant use of restraints and when alternatives to restrain have been exhausted. Except in emergency situations, restraints may not be used without a written order from a physician. Facilities must develop written policy for use of restraint and staff training, and must document all use of restraint and reasons for restraint. Prohibits the use of chemical restraint. Medical Care Comm'n must adopt rules to implement act. Requires that all adult mental health and substance abuse facilities, residential child-care facilities, and adult care facilities report all deaths that occur in a facility to the Dep't of Health and Human Services. Imposes a penalty of not less than $500 nor more than $1,000 for each failure to report and specifies that each day of a failure to report is a separate violation. Each death shall be reported by the Dep't of Health and Human Services to the Governor's Advocacy Council for Persons with Disabilities and the Council shall have access to all information regarding the death. Requires an immediate investigation by the dep't if death occurs within seven days of the use of a physical restraint of the client. Effective January 1, 2001.

Intro. by Carpenter, Phillips, Dannelly, Lucas, Martin of Pitt, Martin of Guilford, and Purcell.

Ref. to Health Care	GS 122C, 131D