SECTION - MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 552
(Replaces A.D. No. 552 dated 10/5/06)

Effective Date: March 8, 2007

SUBJECT: RESTRAINT AND/OR SECLUSION

I. PURPOSE

To establish consistent procedures, in regard to the practice of Seclusion and Behavioral Restraint.

II. AUTHORITY

By order of the Deputy Director, Long Term Care Services and in accordance with California Health and Safety Code Sections 1180.1–1180.5; California Code of Regulations, Title 22, Sections 71545 and 73523; Department of Mental Health (DMH), Special Order 119.06.

III. POLICY

A. The DMH strives to ensure that each Individual served is thoroughly assessed and interventions are designed and implemented to meet the Individual's needs. The use of seclusion or restraint shall be avoided whenever possible and used only to ensure the safety of all persons after all verbal and less restrictive interventions have failed. The use of seclusion or restraint is appropriate only when the Individual or others need to be protected from injury and the use of less intrusive measures poses a greater risk than the risk of using seclusion or restraint.

B. Use of seclusion or restraint must never act as a barrier to the provision of safe and appropriate care, treatments and other interventions to meet the needs of Individuals served. Seclusion or restraint shall not be used as aversive treatment, punishment, retaliation, or for the convenience of staff and shall not be used in lieu of providing recovery-oriented treatment services. Staff shall not threaten the use of seclusion or restraint in an attempt to gain compliance from an Individual.

IV. METHOD

Definitions:

A. Authorized Restraint Devices – Behavioral:

1. Belts and cuffs – any combination of restraints fastened around the Individual's wrists, waist and/or ankles in order to limit the range of motion of arms and legs. The use of ankle restraints is considered non-ambulatory.

2. Posey Belts – devices specifically designed to restrain a seated Individual to a chair.

3. Gloves and Mittens – items designated to keep an Individual served from harming self (e.g. scratching, picking at wound).

4. Five-point restraint – also known as Full Bed Restraint (FBR) is the application of belts and cuffs to the Individual's wrists, ankles and waist, including a posey belt, which is fastened to a bed in a room designated for FBRs.

5. A combination of the above.

B. Authorized Behavioral Restraints (if used) Requiring Medical Director Approval:

1. Walking wrist to waist/ankle restraint – a special procedure behavioral restraint device consisting of leather belts, wrist, and ankle cuffs designed to restrict the range of motion of the Individual's arms and legs. Use of these devices affords an added degree of safety for others while enabling the Individual to participate in the unit milieu, to a limited extent, in certain activities not requiring full mobility.

2. Chair restraint – the use of restraints with a chair affords an added degree of safety for others while enabling the Individual to participate in the therapeutic milieu, to a limited extent in certain activities not requiring full mobility.

C. Authorized Medical Supports:

1. Soft tie as defined above.

2. Gloves and mittens as defined above.

3. Posey Belts as defined above.

4. Side Rails – mechanical safety devices, attached to the sides of beds, to prevent falls from the bed.

D. Authorized Protective Devices:

1. Spit Net – a light weight mesh biological hazard protective device designed to fit over an Individual's head that does not inhibit breathing or vision for the purpose of reducing staff risk of exposure from bodily fluids and or biting.

2. Restraint Blanket – a padded, water resistant blanket which is designed to be utilized when containing an Individual.

E. Behavioral Restraint – the "mechanical restraint" or "manual restraint" practices used to manage an unavoidable dangerous situation. These are last resort interventions used when an Individual presents an immediate danger to self or to others. It does not include restraints used for medical or surgical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure, postural restraints, or devices used to prevent injury or to improve an Individual's mobility and independent functioning rather than to restrict movement. It also does not include any type of mechanical or physical restraint used by the hospital police or law enforcement for transport, security or custodial purposes.

F. Chemical Restraint – any medication used to control behavior or restrict the Individual's freedom of movement that is not a standard treatment for the Individual's medical or psychiatric condition. "Chemical" restraint, as defined in this administrative directive, is prohibited and clearly distinguished from emergency medication. Medications that comprise regular medical regimens (including PRN medications) are not considered chemical restraints, even if their purpose is to assist the Individual with self control.

G. Containment – the brief physical restraint of a dangerous Individual for the purpose of prevention of harm to self or others.

H. Emergency – a situation in which action to impose treatment or safety measures over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the Individual or others, and it is impractical to first gain consent. It is not necessary for harm to take place or be unavoidable prior to intervention or treatment.

I. Emergency Medication – a medication given over the Individual's objection that is immediately necessary for the preservation of life or the prevention of serious bodily harm to the Individual or others, and it is impractical to first gain consent. It is not necessary for actual harm to take place or become unavoidable prior to the administration of an emergency medication.

J. High-Use Notifications – the increased oversight and monitoring resulting from extended periods of seclusion or restraint to ensure that the Individual's needs are being met and ensure availability of resources needed by the treatment team.

K. Mechanical Restraint – the use of a mechanical device or equipment (for either behavioral emergencies or medical purposes) attached or adjacent to the Individual's body that the Individual cannot easily remove and restricts freedom of movement of all or part of the Individual's body (e.g. 5-point restraint).

L. Positive Behavior Support (PBS) Plan – the use of a problem-solving approach to understanding the reasons for an Individual's maladaptive behavior and designing comprehensive interventions that are match to hypotheses about why the maladaptive behavior is occurring and to the Individual's unique social, environmental and cultural milieu. A critical goal of PBS plans is not only to reduce maladaptive behaviors in the short term, but also to help the Individual achieve life-style changes in the long term.

M. Preference Plan – any tool used during admissions and throughout the stay of an Individual served to elicit preferences for treatment, emergencies and interactions with staff or others.

N. Physical or Manual Restraint/Hold – manual hold of an Individual that restricts freedom of movement of all or part of a person's body or to restrict access to the person's body when used as a behavioral restraint. A physical restraint or manual hold does not include briefly holding a person without undue force in order to calm or comfort, or physical contact intended to gently assist a person in performing tasks or to guide a person from one area to another.

O. Prevention and Management of Assaultive Behavior (PMAB) – the procedure used by staff to recognize risk factors for violence and utilize proper preventive therapeutic behavioral management skills to de-escalate a potential crisis or emergency event.

P. Prone Restraint/Containment – the use of a mechanical device to restrain an Individual face down or the placement of an Individual in a face-down position during containment.

Q. Psychiatric or behavioral PRN Medication – prescribed by a physician for specified and individualized behaviors for an appropriately limited time and administered as needed. Within one hour of administration of PRN medication nursing staff must assess the Individual and document the Individual's response.

R. Seclusion – the involuntary confinement of a person alone in a room or an area from which the person is physically prevented from leaving. It does not include those instances when an Individual is restrained in a room and is prevented voluntary egress by virtue of the restraints. Seclusion also does not apply to correctional settings such as mental health programs located within a state prison or to "time-out" strategies wherein an Individual agrees to remain in an unlocked room or area and maintains the choice to leave.

S. Serious Injury – a significant impairment of the physical condition of an Individual or staff as determined by qualified medical personnel that requires medical attention beyond first aid and includes, but is not limited to burns lacerations, bone fractures, substantial hematoma, or injuries to internal organs.

T. STAT medication – a prescribed medication by a physician in response to a psychiatric or behavioral emergency (as described in H) and is administered immediately by a nurse. Each psychiatric or behavioral emergency requires a new physician order which can be written or verbal. Within one hour of administration of STAT medication nursing staff must assess the Individual and document the Individual's response. Within 24 hours of the administration of a STAT medication, a psychiatrist must conduct a face-to-face assessment of the Individual with the exception that a physician may undertake the assessment during weekends and holidays. The assessment shall address the reason for the STAT administration, Individual's response, and as appropriate, adjustment of current treatment and/or diagnosis.

U. Wellness and Recovery Plan – a comprehensive case formulation for each Individual that emanates from interdisciplinary assessments of the Individual. This plan specifies the Individual's focus of hospitalization, assessed needs and how the staff will assist the Individual to achieve his goals and objectives.

V. Nurse – any nursing staff, i.e., Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Psychiatric Technician (PT).

V. GENERAL PRINCIPLES AND EXPECTATIONS

A. All staff must view the need for, and use of, seclusion or restraint as a rare and extreme situation wherein the life or safety of the Individual or others is imminently at risk and all other possible interventions have failed. As such, a Special Incident Report (SIR) shall be completed each time seclusion, mechanical restraint or a physical restraint is initiated.

B. Staff recognition of triggers, precursors or other warnings displayed by an Individual that are known to lead to dangerous or unsafe situations shall warrant, and prompt, the immediate use of individualized treatment measures, including safety techniques and interventions identified as preferred by the Individual.

C. Staff shall not presume the need for seclusion or restraint based solely on the Individual's previous need for these emergency interventions or based solely on a history of dangerous behavior. Evidence of current imminent harm at an emergency level with a failure of all other possible options must be presented each and every time the use of seclusion or restraint is utilized to ensure safety.

D. Medications:

1. Medications shall not be used as a chemical restraint. PRN (as needed) medications may be offered to the Individual during a period of increasing agitation or may be given involuntarily when the behavior threatens the safety of the Individual or others, but must be limited, according to clinical judgment and medication guidelines, to the least amount required to lessen the dangerous behavior.

2. The use of psychiatric PRN medication and STAT medication requires that:

   a. Medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the Individual's distress.

   b. PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.

   c. PRN medications are appropriately time-limited. Within one hour of administration of STAT or PRN medication nursing staff must assess the Individual and document the Individual's response.

E. Staff shall afford to Individuals who do require restraints, the least number of restraint points and the maximum freedom of movement that will ensure the physical safety of the Individual and others.

F. The Individual shall be made aware of the reason seclusion or restraint is necessary and the safe behavioral criteria needed for the emergency intervention to be discontinued.

G. The Individual's safety, dignity and rights will be preserved at all times when either seclusion or restraint is used.

H. For any Individual placed in seclusion or restraints more than 3 times in any 4-week period, the Individual's Wellness and Recovery Planning team will review the Individual's Wellness and Recovery Plan within 3 business days and modify the plan as clinically appropriate.

VI. ASSESSMENTS AND EFFORTS TO AVOID EMERGENCY INTERVENTIONS

A. Assessments and History:

A discussion and review of the Individual's history shall occur to obtain information about Individual skills and preferred treatment interventions to avoid an emergency. The initial and/or integrated assessment, history, preferences and treatment interventions shall be documented and shall address all of the following:

1. Inform the Individual of seclusion or restraint policies and procedures and the goal to prevent behavioral emergencies that lead to the use of restrictive control measures.

2. Identify any pre-existing medical condition(s) or any physical disabilities that would place the Individual at greater risk during seclusion or restraint.

3. Identify history of trauma, sexual or physical abuse that may place the Individual at greater psychological risk during seclusion or restraint.

4. Identify Individual characteristics, stressors, triggers and environmental factors that may contribute to an Individual experiencing distress that, if not properly addressed, may be warning signs of behavioral difficulty or an emergency. Items 1-4 above shall be included in the Unit's card file that is used during morning and/or inter-shift reports.

5. Assist the Individual to identify tools, actions, or interventions that would help the Individual manage behavior and have needs met in proactive and pro-social ways.

6. Involvement of the family or others when possible (with permission of the Individual) who may have helpful information about what tools or strategies to use and strategies to avoid. Items 1-6 above shall be addressed at Treatment Planning Conferences (TPCs).

B. Identifying Triggers, Warning Signs and Environmental Factors:

Treatment staff shall remain cognizant of, and have the ability to recognize identified antecedent behaviors and the internal triggers (e.g., thoughts, emotions, thought disorder and other psychotic symptoms) and external triggers (e.g., sights, sounds, scents, etc.) for each Individual they serve that may precede significant distress, and shall initiate appropriate proactive intervention. Proactive intervention may include:

1. Administration of a voluntary medication (PRN) or an emergency medication (involuntary) if the behavior is reaching an emergency status.

2. Referencing the Individual's preference plan and utilizing feasible activities or interventions of choice documented by the Individual and/or facilitating communication with staff, other Individuals, a family member or friend.

3. Development of an integrated PBS Plan or psychological intervention plan during TPCs.

C. Incident Reviews and Debriefings:

Problem solving and avoiding future emergency incidents or the use of seclusion or restraint shall occur through the special incident review process and review of post-incident debriefings, on going assessments, and updating of treatment interventions (reference Section VIII, F of this policy for more specific debriefing procedures).

VII. SPECIAL CONSIDERATIONS

Certain medical and/or psychological conditions and the positioning of the Individual during the containment and restraint process warrant heightened staff awareness and the use of special precautionary nursing and monitoring measures to avoid undue harm to the Individual served.

A. Medical/Physical Precautions – special consideration shall be given whenever an Individual served has a history of a medical/physical condition that would place the Individual at greater risk.

B. Psychological Precautions – special consideration shall be given whenever an Individual served has a history of trauma, sexual or physical abuse that would place the Individual at greater psychological risk during seclusion or restraint.

C. Prone Position Precautions – the prone position for mechanical restraints is prohibited. The prone position during floor containment is to be avoided to the greatest extent possible in order to prevent the potential risks of respiratory distress or positional asphyxia. The contraindications that increase the risk for positional asphyxia are:

1. Asthma
2. Chronic Obstructive Pulmonary Disease (COPD)
3. Emphysema
4. Overweight/Obese
5. Abnormalities (e.g., one lung, enlarged heart, chest deformities)
6. Individual's level of psychological agitation
7. Length of time of extreme physical exertion/resistance by the Individual
8. The number of staff involved in the containment
9. Positioning of staff on or around the Individual's body

D. Seclusion or restraint is always contraindicated when:

1. The Individual's behavior can be controlled with less restrictive methods.

2. The "imminent danger" has subsided and the emergency no longer exists.

3. The release criteria for seclusion or restraint have been met.

VIII. EMERGENCY INTERVENTION PROCESS

A. Establishing When an Emergency Exists:

The decision to utilize seclusion or restraint must be based on the current presentation of dangerous/violent behavior wherein serious bodily harm or loss of life to the Individual or others is imminent without immediate physical intervention. Although it is not necessary for actual harm to take place to establish an emergency and use seclusion or restraint, the following criteria must also be considered before making the final decision:

1. All other attempts to diminish the dangerous behavior without physical contact have failed or will be insufficient to prevent serious bodily harm from immediately occurring.

2. Verbal threats of harm to self or others or the use of foul language by the Individual are not used as the sole basis for establishing an emergency.

3. Slamming a fist on the wall or table, kicking chairs, spitting or other similar behaviors may not necessarily result in imminent serious bodily harm to the Individual or others and shall not be the sole indicator for utilizing seclusion or restraint.

4. If an assault on another has occurred, staff must determine/assess if the assaultive behavior is likely to continue (preventing use of any de-escalation techniques) prior to moving forward with a physical intervention.

B. Containment Procedure:

When a physical intervention has been determined to be a necessary last resort measure, the following process shall be followed:

1. The Individual shall be contained with the least amount of physical force possible and only by staff trained in the use of PMAB techniques.

2. The Individual shall be contained in a manner that avoids, if at all possible, placing the Individual face-down on the floor in a prone position. If the prone position is unavoidable and does occur, staff must be cognizant to avoid pressure on the neck, back or any area of the upper torso that may inhibit adequate respiration and must reposition the Individual as soon as possible. Monitoring of the Individual's respiration and physical well-being shall be continuous during the entire containment process by a staff person who is not physically participating in the event.

3. The Individual shall be released from containment without the application of seclusion or restraint when it is determined that the violent or aggressive behavior that created the emergency is no longer displayed, and there is no continued threat of harm to the Individual or others.

4. If an emergency, as defined, continues after the containment has been accomplished, the Individual shall be transported to a restraint room in a supine or non-prone position. If spitting, biting, urinating or other public health hazards occur, staff may utilize any type of approved shield for protection that does not interfere with the Individual's respiration, vision or ability to communicate.

C. Seclusion and/or Restraint Room – General Requirements:

Upon placing an Individual in restraints or in a seclusion room, the following actions shall occur:

1. As soon as possible, the Individual shall be informed of why seclusion or restraint is necessary and the dangerous behavior that must cease before release can occur.

2. All Individuals in restraint shall be observed continuously in-person. If, however, the staff's presence in the room is agitating to the Individual, observation may occur for a brief period through the window of an unlocked door.

3. No later than 15 minutes after initiation, the Individual shall be assessed for the need of seclusion or restraint, contraindications for seclusion or restraint, and the proper application of any restraint by the physician/psychiatrist, or registered nurse.

4. If the assessment is performed by a registered nurse, there shall be an additional assessment by a physician/psychiatrist performed within one hour.

5. The physician/psychiatrist order for seclusion or restraint shall be obtained as soon as possible and no later than 15 minutes after the application of seclusion or restraint.

6. The length of any physician/psychiatrist order for seclusion or restraint shall be determined by the current clinical situation. Orders for adults (initial and each renewal) shall be for a maximum of four (4) hours. Renewal orders shall only be provided after an assessment by a physician/psychiatrist or registered nurse, and documentation of justification for continued use is indicated.

7. The Individual shall be re-assessed by the registered nurse or a physician/ psychiatrist, no less than once (within 2 hours), prior to the expiration of the order to evaluate that Individual's condition and the need for continuing the seclusion or restraint. This does not preclude release from restraint prior to expiration of the order at any time staff assessment indicates the Individual is no longer dangerous.

8. When a medical/physical condition develops that contraindicates the use of seclusion or restraint, the Individual shall be released and the physician/ psychiatrist notified immediately to evaluate the condition of the Individual.

D. Safety, Dignity and Patients' Rights of Individuals shall be preserved when seclusion or restraint is used:

1. The room used for seclusion shall provide maximum safety, comfort and freedom of movement for the Individual, and have a window that permits a view of the room. The room shall also have appropriate light and ventilation.

2. While providing continuous in-person monitoring during seclusion or restraint use, staff shall protect the Individual from unnecessary observation by others.

3. Individuals shall be restrained in a manner that allows for expedient release in the event of fire or other emergencies.

4. The Individual shall be appropriately attired or covered at all times.

5. The Individual in seclusion or restraint retains the right to see the Patients' Rights Advocate and/or file a complaint.

6. Rights of an Individual are not considered denied unless the Individual actually requests to exercise a specific legal right.

7. When the Individual is under the age of 22 and the intervention of seclusion or restraint prevents or interrupts participation in an educational program, the treatment plan shall address how the Individual's education program will be provided until the ability to return to school is re-established.

E. Release Criteria:

The Individual shall be released from seclusion or restraint when the violent or dangerous behavior that created the emergency is no longer displayed. In addition, the following criteria must be applied:

1. No Individual shall be permitted to sleep in restraints without justification and regular assessment per policy. Staff will give every consideration to utilize less restrictive means throughout the period of sleep, and will document the reason(s) after each assessment why release from restraints and/or less restrictive means will not prevent harm to the Individual or others.

2. Release from seclusion or restraint shall not be contingent upon the ability of the Individual to:

   a. Verbally say they recognize what behavior prompted the seclusion or restraint, or that they are sorry for their actions.

   b. Verbally contract for safety.

   c. Agree to cease using foul language and/or making verbal threats.

3. Release from seclusion or restraint shall not be contingent upon the ability of the Individual to be reintegrated into the unit milieu without one-to-one supervision or other supports that may be needed.

F. Post-incident Debriefings:

After every seclusion or restraint episode, staff shall conduct a post-incident debriefing to assist the Individual and staff in identifying what led to the incident and to identify what can be done differently to avoid similar situations in the future. Form MH 2507, Seclusion/Restraint Debriefing Form shall be used to document information learned from the event and shall encompass the minimum guidelines provided below. Debriefings shall:

1. Be conducted as quickly as possible, but no later than 24 hours after the Individual's release from seclusion or restraints. A full treatment team post-debriefing may be delayed until the next working day.

2. Include participation by the Individual (encouraged, but only if voluntary), the staff members involved in the incident (if reasonably available), a supervisor, and, if the Individual requests it and it is possible, the person's significant other, domestic partner, family member, or conservator (if the third party can participate at the time of the debriefing in accordance with security restrictions and at no cost to the facility) to discuss how to avoid a similar incident in the future. Phone contact with family/others may be substituted for a face-to-face meeting.

3. Include the following:

   a. The Individual's experience of the incident (what happened and why).

   b. The Individual's feelings before, during and after the event.

   c. Suggestions for "changes" – what the staff and Individual can do differently to prevent another similar situation.

4. Post debriefing activities – information obtained from the debriefing shall be used to accomplish the following:

   a. Determine and implement treatment modifications to address the Individual's internal and external provocations, precursors and behavior chains leading up to the incident;

   b. Review of the Individual's PEP plan, or other identified Individual preferred techniques or interventions for avoiding behavioral emergencies;

   c. Review mental status assessments, the PMAB and de-escalation techniques, unit rules, staff response to Individual needs prior to, or during the crisis situation to more effectively restore the Individual to safety.

5. Post Incident Debriefing form filing:

   a. All completed PDF shall be filed in the Individual's medical record.

   b. A copy shall be immediately submitted to the Standards Compliance Department.

IX. TRAINING AND EDUCATION

A. Training Goals and Improvements:

1. All staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or STAT medication shall successfully complete competency-based training regarding implementation of all policies and the use of less restrictive interventions.

2. Effective training for administrators and all clinical disciplines is essential to facilitate the cultural, philosophical and clinical practices necessary for improvements that lead to minimizing seclusion and restraint use. Through the sharing of best practices in the recovery treatment model, state hospitals are to develop or enhance training in the following areas:

a. Increase staff competencies in the efficient use of: problem solving, alternative dispute resolution strategies, effective methods to avoid and/or de-escalate "power struggles" between Individuals, and between Individuals and staff. This includes the effective practices to resolve conflicts that may occur between staff disciplines and/or between shifts or departments that ultimately hinder healthy working relationships, role modeling and the therapeutic milieu.

b. Increase staff competency to model and teach Individuals effective communication, mindfulness techniques, emotional management, and stress reduction skills.

c. Augment existing PMAB Training with additional strategies and tools (e.g., clinical assessments and verbal skills) to effectively avert the need for physical intervention, seclusion or restraint.

B. Augment Individual and family education about when and why seclusion or restraint could become necessary and the goals, prevention methods and alternatives that may facilitate a reduction in the need for these emergency interventions.

C. Enhance staff competencies in the understanding, identification and treatment of the effects from trauma.

D. Mandated Training – employees participating in the containment, seclusion or restraint of Individuals shall be current in required PMAB Training Classes. Nursing staff shall also be current with procedures for the proper application of restraints and nursing care requirements as identified in the Nursing Care Procedure Manual.

X. DATA COLLECTION, REPORTING AND ANALYSIS

Data collection and analysis is crucial in the effort to reduce behavioral emergencies and safely and effectively minimize seclusion and restraint use. Varied, detailed and reliable data allows the hospital to identify strengths, flag problem areas, benchmark with other settings, review unit or clinician-specific trends, and to implement improvements appropriately and effectively.

A. Internal Data Collection – under the direction of the Standards Compliance Director, data concerning the use of restraint and/or seclusion shall be collected, analyzed, and disseminated within the hospital for incorporation into the facilities' goals and objectives.

B. Headquarters' Reportable Data – as determined by the statewide data collection team, specific elements of data shall be reported to headquarters for inclusion in the state hospital quarterly seclusion and restraint report that is posted on the DMH internet web page. Minimum monthly reporting elements include:

1. Hospital identification number.

2. Individual identification number.

3. The number of incidents of seclusion and the duration of time spent in seclusion (date, time in and time released).

4. The number of incidents of restraint and the duration of time spent per incident in restraint (date, time in and time released).

5. The number of incidents that an emergency medication, as defined in this Administrative Directive was administered to an Individual in response to a behavioral emergency.

6. The number of incidents where a serious injury, as defined in this Administrative Directive has occurred to either the individual and/or staff during seclusion or restraint use or during the containment process.

7. The number of incidents where a death occurred as a direct result of or in relation to the use of seclusion, restraint or the physical intervention and containment process.

C. Reports to the Protection & Advocacy Agency (PAI):

In addition to reporting seclusion and restraint related deaths to the Center for Medicaid and Medicare Services (CMS) as required by federal law and to the Licensing Division of California Department of Health Services, each state hospital is required to report each incident of a serious injury to or death of an Individual served that may be related to containment, seclusion or restraint to the PAI. The report to PAI must be made no later than the close of business of the day following the serious injury or death and will be provided by mailing or faxing a notification form letter.

W. T. VOSS
Executive Director

Cross Reference(s):
A.D. No. 526 Suicide Prevention
A.D. No. 554 Prevention and Management of Assaultive Incidents of Individuals
A.D. No. 604 Patients' Rights Advocacy Program
A.D. No. 610 Procedure for Documentation of Denial of Rights