

August 25, 2014

Elizabeth Timm
Office of Childcare Licensing
1825 Faulkland Road
Wilmington, DE 19805

RE: DFS Proposed Residential Child Care Facility and Day Treatment Program Regulation [18 DE Reg. 122 (August 1, 2014)]

Dear Ms. Timm:

The Governor's Advisory Council for Exceptional Citizens (GACEC) provided comments on earlier proposed revisions of this regulation in June, 2013, August, 2013, January, 2014, and May, 2014. The Division of Family Services has opted to publish a revised 77-page proposed regulation. The latest regulation includes a list of Council comments and the amendments from the Division, if any, prompted by each comment. At pp. 123-124.

The itemized comments submitted by the GACEC and essence of the italicized responses from the Division are as follows:

1. In §1.3, definition of "residential child care facility", psychiatric hospitals and foster homes are excluded from coverage. However, the status of a pediatric skilled nursing facility is unclear. Exceptional Care for Children in Newark is an example. DHSS ostensibly licenses such facilities pursuant to Title 16 DeL.C. §§1119B and 1119C. However, such facilities may also meet the DFS definition of "residential child care facility". DFS may wish to clarify coverage or non-coverage of pediatric nursing facilities.

Response: DFS does not regulate pediatric skilled nursing facilities and foster homes are regulated under a different set of DFS regulations. No change was made to regulation.

2. In §1.4, definition of "Administrative Hearing", the reference to "...place the facility on the enforcement actions of Warning..." is awkward language. DFS may wish to revise the reference.

Response: The definition was revised.

3. Section 17.3 contemplates HRC review of “restrictive procedures” and “proper treatment”. It is unclear if DFS envisions HRCs reviewing psychotropic medications. Section 1.4, definition of “restrictive procedure”, only covers drugs which qualify as a “chemical restraint”. The definition of “chemical restraint” excludes “the planned and routine application of a prescribed psychotropic drug”. Therefore, if a child were prescribed heavy daily doses of multiple psychotropic drugs, the HRC may arguably lack jurisdiction to review. By analogy the DDDS HRCs review regularly prescribed psychotropic drugs administered in covered facilities, including co-DHSS/DFS regulated AdvoServ. DFS may wish to consider whether HRC review of psychotropic drugs excluded from the definition of “chemical restraint” merit HRC review.

Response: The HRC determines if “children in care are receiving proper treatment” which would include review of psychotropic medications regardless of whether they amount to a “restrictive procedure”.

4. In §1.4, definition of “Consultant”, there is a plural pronoun (their) with a singular antecedent (practitioner). Consider substituting “the practitioner’s” for “their”.

Response: Grammar has been corrected.

5. In §1.4, definitions of “Exclusion” and “Locked Isolation”, it is somewhat anomalous to categorically bar use of unlocked exclusion for kids under age six but have no equivalent limit for locked isolation. DFS may wish to consider adding a similar age standard in the definition of “locked isolation”.

Response: “Locked isolation” is a “restrictive procedure” which, by definition, may not be used for on any child under age 6. However, the definition of “restrictive procedure” has been modified to provide additional clarity.

6. In §1.4, the definitions of “exclusion” and “time-out technique” are not well differentiated. Placing a child in an unlocked classroom or office would fit both definitions. Section 3.12.9.3.2 reinforces the overlap by stating that “time-out” may not occur in closet, bathroom, unfinished basement or attic. The implication is that placement in other rooms is an acceptable use of “time-out”. If a provider were considering placement of a child under age six in an unlocked room, that would be barred under the “exclusion” definition (and §17.1.2) but allowed per §3.12.9.3.3 if characterized as “time-out”.

Response: Additional wording has been added to insure continuous monitoring of children under age 6 while in time-out and the time frame for monitoring of children over age 6 has been changed.

7. A related anomaly to that described in the preceding paragraph is that an exclusion requires “continuous” monitoring (§1.4, definition of “exclusion”; §17.5.1.1) while time-out only requires a visual check every 30 minutes (§3.12.9.3.2). If a provider wishes to avoid the continuous monitoring requirement, the provider would simply characterize placing a child in an unlocked room as “time-out”. Moreover, the implication of 30-minute checks is that “time-out” periods are extended. Clinically, a time-out should permit some time to reflect and regain self-control. A time-out should not last for hours. Cf. §3.12.9.3.3, time-out for children under six should not exceed one minute for each year of age.

Response: The regulation has been amended and the monitoring time changed for time-out for both children over and under 6 years of age to provide additional clarity.

8. Section 17.5.1.1 raises a similar concern. Within each two hours of a restrictive procedure, a child is given an opportunity for 10 minutes of release. Based on the definition of “restrictive procedure”, this suggests that extended periods of mechanical restraint, locked isolation, and exclusion are acceptable norms. This section could also be interpreted to authorize a facility to limit access to a toilet to once every two hours. The structure of the DFS regulations appears to allow sequential use of restrictive procedures resulting in extended isolation. For example, §17.5.1.1, in combination with §17.7.1.3, authorize a two hour locked isolation followed by a 10 minute break, another two hour locked isolation followed by a 10 minute break, and then a third two hour locked isolation. Similarly, per §§17.5.1.1. and 17.6.1 and 17.6.2, “exclusions” can be “stacked” resulting in removal of a child to an unlocked room for an hour, followed by a 10 minute break, which can be repeated for an aggregate of six hours. Similarly, per §§17.5.1.1 and 17.9.1.4, “mechanical restraints” can be “stacked” resulting in two hours of mechanical restraint, followed by a 10 minute break, followed by another two hours of mechanical restraint. Temporal limits on “consecutive minutes” of a restrictive procedure (e.g. §17.7.5 and 17.9.1.4) are easily circumvented by allowing short breaks to toilet or stretch. DFS may wish to consult DPBHS to assess whether the above regulations conform to contemporary clinical standards in the field. The Terry Center has converted its former seclusion room to a children’s store.

Response: The regulations have been amended to place further limits on the use of restraints.

9. There is some “tension” between §3.12.10.1.3 and 17.5.1.1. The former section contemplates the release of a child from a restraint after no more than 15 minutes while the latter would authorize restraint for at least two hours.

Response: Additional text has been added to §17.5.1.1 to provide clarity.

10. In §3.5.5, DFS requires a “direct care worker” (who only needs a high school diploma) to be at least 21 years of age. Some states have promoted college students working as support staff in group homes and similar facilities since they generally represent a demographic group with some intellectual wherewithal. Students seeking degrees in social work, psychology, etc. may be very interested in working in an RTC or specialized child care setting for experience. However, since §3.5.5 requires a direct care worker to be 21, many college students would be categorically barred from such employment. DFS could consider either: a) reducing the age to 18; or 2) adopting a standard of at least 21 or, if the applicant is a college student, 18. DFS could also consider only allowing employment of 18-20 year old college students with a minimum number of credits in a social services field (e.g. social work; psychology).

Response: Because children in care could be 17 years of age, the Division would like to preserve a desirable age span difference between workers and children. No change was made to regulation.

11. In §3.12.5.5, DFS may wish to add a reference to referrals to the Pathways to Employment program for qualifying adolescents. See 17 DE Reg. 1070 (May 1, 2014).

Response: DFS prefers to keep the listing of services for adolescent children non-specific, allowing the licensee to incorporate appropriate and available programs that may change over time. No change was made to regulation.

12. There are several authorizations to use restraint to prevent destruction of property. See, e.g. §1.4, definition of “non-violent physical intervention strategies”; and §3.12.10.1.2. When the Legislature adopted S.B. No. 100 in 2013, it did not authorize use of restraints in public school educational settings based on property destruction. See 14 Del.C. §4112F(b)(2). If a child is tearing paper, throwing a pencil or eraser, or ripping buttons off his/her clothes, the DFS regulation authorizes use of physical and possibly mechanical restraint. DFS may wish to at least consider a more “restrained” authorization. For example, if the property destruction implicates a threat of bodily harm (e.g. throwing a desk or punching a wall), restraint may be justified. The DFS regulation is simply too “loose” in authorizing restraint based on any, even minor, property destruction.

Response: This authorization has been removed.

13. Section 4.7.1 can be interpreted in two ways: a) facilities must be free of lead paint hazards if they accept kids under six who either have an intellectual disability or severe emotional disturbance; or b) facilities must be free of lead paint hazards if they accept kids under age 6 OR with intellectual disabilities of any age OR with severe emotional disturbance of any age. Council suspects DFS intends the latter. Moreover, the term “severely emotionally disturbed” violates Title 29 Del.C. §608 and should be modified. However, Council feels that facilities must be free of lead paint hazards regardless of the age or intellectual or emotional disability of the child.

Response: The lead paint reference and the reference to “severely emotionally disturbed” have been revised.

14. In §7.0, DFS should consider adding a provision to address electronic cigarettes. See attached statement of the American Lung Association and articles describing H.B. No. 241 and H.B. No. 309.

Response: Wording was added.

15. Section 3.12.10.1.4 requires persons implementing physical intervention strategies to be “specifically trained in its use...and have current certification, if applicable.” This standard is very unclear and confusing. When is a certification applicable? Does some in-house training suffice?

Response: Text has been amended to improve clarity.

In addition to the comments submitted in May, Council would like to share the following observations on the revised proposed regulations published in the August, 2014 Register of Regulations:

1. In §1.0, the definition of “parent” encompasses guardians. However, there are many references throughout the regulation to “parent or guardian”. See, e.g., §§3.12.3, 3.12.11.1.3, and 5.2.1.4. The Division may wish to employ a “search” tool to locate such extraneous references to guardians and convert them to simple “parent” or “parents”.

2. In §1.0, definition of “restrictive procedure”, it would be preferable to amend the reference to “appropriately trained and credentialed personnel”. This would be consistent with §3.12.10.1.3. Moreover, only a physician or advance practice nurse should be authorized to order a chemical restraint.

3. In §2.10, final bullet, DFS may wish to delete “during operating hours”. For example, if the facility

reported a death “after working hours” per §3.1.1, DFS may not wish to wait until normal business hours to arrive on-site. Evidence could be stale or compromised. The “operating hours” limitation is not contained in §2.2.2. By analogy, long-term care licensing standards do not limit staff access to business or operating hours. See, e.g. Title 16 Del.C. §§1105(4) and particularly 1107(c): “Any duly authorized employee or agent of the Department may enter and inspect any facility licensed under this chapter without notice at any time.”

4. In §2.11, “AppeaL” should be “Appeal”.

5. In §3.12.7.7, consider adding “trampoline jumping”. See attached September 24, 2012 article describing position of American Academy of Pediatrics.

6. Section 3.12.9.3.2 merits amendment.

A. While §3.12.9.3.3 requires continuous monitoring of a child under age six in time-out, §3.12.9.3.2 allows children ages six and above to be placed in time-out with only visual checks at 15 minute intervals. This is highly objectionable. The child placed in time-out may be very emotional and upset. For example, §3.12.9.3.3 contemplates extended time-out up of “60 consecutive minutes) if the child refuses to cooperate within the time-out.” Having 15 minutes checks under these circumstances is dangerous. By analogy, “exclusion” of children age six or older requires continuous visual monitoring. See §17.6.3.1.

B. A second concern with §3.12.9.3.3. is that it allows “stacking”. A child age six or older could be subjected to a 60 minute time-out, given a five minute bathroom break, subjected to another 60 minute time-out, given a five minute break, subjected to another 60 minute time out, etc. During this time, the child may be isolated in a separate room as long as the room is not a “closet, a bathroom, or an unfinished basement or attic.” See §3.12.9.3.2. While “exclusion” and “locked isolation” contain some cumulative standards to deter “stacking” (§§17.6.2 and 17.7.1.3), there are no such limits on time-out.

7. Section 4.1.6 requires the premises to be rodent-free. At a minimum, the Division may wish to consider addressing bed bugs as well given the highly-publicized prevalence of infestations. In a related context, the Division may wish to consider requiring zippered mattress and pillow protectors for two reasons: a. protection from bed bugs, dust mites, etc.; and b. protection from fluids. See, e.g., attached CDS Bed Bugs FAQs and excerpt from USBedBugs.com. For example, §19.11.2.6 literally requires a mattress wet by an infant to be immediately replaced. Replacing a mattress every time a leaky diaper wets a mattress is not realistic. Section 9.14.2.2 requires mattresses to be “cleanable”. This standard could be embellished to require a mattress protector which is more easily cleaned than mattress fabric or a cloth mattress pad.

8. While there are standards on dishwashing to deter spread of germs (§4.2.3), Council did not notice equivalent standards regarding laundry sanitation. For example, if cloth diapers among various infants are laundered together, that can spread diseases, especially since there are no temperature, bleach, or disinfectant standards. See, e.g., §§5.6.2.1 (allowing cloth diapers); 19.11.2.7 (allowing mixed laundering); and 19.11.2.9 (allowing mixed laundering). The implication of §5.6.2.2 (requiring separate bag of soiled diaper/training pants with infant name) is that laundering should be separate and not commingled. See also §9.9.1, third bullet. However, this is not explicit and facilities may simply launder clothes together. DFS may wish to consider clarifying expectations.

9. Section 17.1.2 categorically bars use of restrictive procedures on children below age six. DFS may wish to consider whether this includes a physician order for a chemical restraint (§17.8.1). Reasonable persons may differ on the use of drugs to affect behavior on children below age six.

10. Sections 17.5-17.9 contain some safeguards for extended use of restrictive procedures, including HRC and chief administrator review. DFS may wish to consider requiring facilities to report instances of extended use of restrictive procedures above a certain threshold to the Division. This provides an additional deterrent to “overuse” and enhances monitoring. Compare Title 16 Del.C. §5162.

11. DFS may wish to consider adding “mat wraps” to §17.9.3.

Thank you in advance for your time and consideration of our observations. Please feel free to contact me or Wendy Strauss should you have questions or concerns.

Sincerely,

Robert D. Overmiller
Chairperson

RDO:kpc

Attachments