REQUEST FOR PROPOSAL

A/E-RFP#02-2022

ARCHITECTURAL & ENGINEERING SERVICES

ISSUED: February 25, 2022
RESPONSES DUE: April 15, 2022

LIFEPATH SYSTEMS
1515 HERITAGE DR.
MCKINNEY, TX 75069
972-562-0190

For RFP Project Questions:
Randy Locke
Facilities Manager
rlocke@lifepathsystems.org

For RFP Submittal Questions:
Willy Villavicencio
Purchasing Manager
wvillavicencio@lifepathsystems.org

REQUEST FOR PROPOSAL (RFP) A/E-RFP#02-2022

ARCHITECTUAL & ENGINEERING SERVICES

Background Information

Collin County Mental Health Mental Retardation Center d/b/a LifePath Systems (the "Center") was founded in 1986. It is the Local Behavioral Health Authority (LBHA) and the Local Intellectual and Developmental Disabilities Authority (LIDDA) for Collin County, Texas as authorized by the Texas Health and Human Services Commission (HHSC). In addition to its role as Authority, the Center is a provider of behavioral health services and a provider of services for individuals with intellectual or developmental disabilities.

Throughout this RFP, reference to "Center" is assumed to define and include LifePath Systems. Reference to the "firm" is assumed to include the architectural firm and any other firms and/or personnel with which the firm has elected to partner for purposes of this project, to include project engineering. The firm will be responsible for all communications, contracting, payment, and other matters with partner firms and personnel selected by the design firm. This will include documentation required by federal, state and/or local funding sources.

Project Background and Objectives

The Center is seeking an architectural firm to design a new multi-use campus, that will include, but not limited to office space, crisis services and jail diversion services with adequate parking. The firm will be expected to design a public services facility that improves the connectivity between the Center's programs while enhancing the experience of our clients visiting the facilities. Experience in the design of hospitals, mental health facilities and government facilities is highly desirable. Special consideration to HHSC item V "Crisis Service Standards" section on facilities must be met. The winning firm will be required to obtain at least 3 bids from contractors to perform and manage the construction portion of the project.

The Center is seeking qualifications from professional firms to provide architectural and engineering services for the construction of the new multi-use campus in McKinney, TX. The project site will be located on an 11.493-acre tract, Property ID 1988776, directly across the street from the Collin County Administration Building 2300 Bloomdale Rd. McKinney, TX 75071. The new campus is anticipated to not exceed 65,000 square feet of office space and a Crisis Center of 45,000 square feet. Integration of backup generator power for the Crisis Center must be included. The Center will build and occupy the multi-use campus that will be constructed on County property that will be leased to the Center.

Scope of Project

The scope of the services to be provided by the A/E Team relative to the Project may include without limitation the general disciplines outlined below to the extent necessary to provide complete, accurate and fully coordinated design documents for the Project:

- Programming and space planning.
- Obtaining approvals of government agencies having jurisdiction over the project.
- Demonstrate a full knowledge of ground leases including use provisions, insurance requirements, and rights of both the landlord and tenant.
- Demonstrate a full knowledge of easement types including utility, prescriptive and easements by necessity as well as possess a thorough comprehension of applicable regulatory standards and mandates.
- Schematic Design (to include stormwater and parking requirements)
- Life Cycle cost analyses and evaluation of various alternative energy conservation options.
- Water efficiency/conservation options.
- Conceptual Plan and Design Development.
- Interior Design (furniture layout, FF&E, signage, etc.).
- Preparation of Construction Documents.
- Bidder participation including mandatory attendance at pre-bid conference and bid reviewal.
- Cost estimating.
- Project close-out assistance.
- Site Master Planning
- Landscape Architecture
- Civil Engineering
- Structural Engineering
- Mechanical Engineering
- Electrical Engineering
- Networking Engineering
- Plumbing and Fire Protection Engineering
- ADA Design
- Building Information Modeling (BIM) for all phases of design
- Code compliance
- Implementation of all requirements of the American with Disabilities Act, HHSC Information Item V, and other federal, state and City of McKinney, Texas requirements
- Energy modeling, building analysis and commissioning
- LEED certified design
- Life Safety Issues including shelter in place for protection against active shooter and severe weather and effective evacuations for active shooter, fire, bomb threat, and other emergencies

The services to be provided by the A/E Team may be divided into the following phases:

Master Planning and Concept Design

- Conduct review of current and planned public utility infrastructure servicing site.
- Develop diagrams for building and site, focusing on building and site size requirements.

Schematic Design

- Prepare Schematic Design documents (“SD”) based on the Center’s project program.
- Consider the value of alternate materials, building systems and equipment based upon program and aesthetics in developing a design consistent with schedule and budget.
- Partner with Center during SD to create a design that is consistent with the Center’s Budget. At the conclusion of SD, submit drawings and scope narrative to for initial cost estimate. If revisions to the SD documents are required to conform to the approved budget, the firm will be responsible to make such revisions without additional fee.
- Prepare basic project materials needed for regulatory and community presentations such as elevation sketches, project description narratives, etc.

Design Development

- Prepare Design Development documents (“DD”) including plans, sections, elevations, construction details, outline specifications, and layouts of building systems.
- Partner with Center during DD to create a design that is consistent with the Project Budget. Submit drawings and a scope narrative to Center for interim pricing during the DD process. At the conclusion of DD, submit a complete cost package to the Center that includes drawings, specifications and a scope narrative as needed to further define scope beyond what is included in the DD level plans and specifications. If revisions to the DD documents are required to conform to the approved budget, the firm will be responsible to make such revisions without additional fee.

Construction Documents/Bid and Award

- Prepare Construction documents (“CD”) consisting of drawings and specifications setting forth requirements for construction in detail.
- Collaborate with the Center to ensure the design is consistent with the approved budget. If revisions to the Construction Documents are required to conform to the approved budget, the firm will be responsible to make such revisions.
- Mandatory participation in pre-bid conferences, prepare responses to questions, provide interpretations/addenda, etc.
- Participate in selection interviews and make recommendations based on bids submitted and interviews conducted.

Required Qualifications

Architectural/Engineering firms that respond to this RFP to serve as the firm must meet all the following criteria:

- Must be experienced as the primary design architect on a project with a construction cost of greater than $15,000,000.00 million dollars.
- Must be experienced as the primary design architect on professional / commercial office space or government healthcare facility, constructed within the last 10 years.
- Must demonstrate sustainable design experience with buildings constructed to LEED Certified standards.
- Must be familiar or familiarize itself in McKinney, Collin County, TX building and fire codes, zoning regulations, and local construction practices.
- Firm and its key project employees, including sub consultants, must have all current licenses, certifications, and registrations to perform the work.
- Firm must be willing to encourage innovation during architectural design phases with characteristics interconnected Collin County culture.
- Firm must be familiar with conditions listed in HHSC Information Item V (attached) section relating to facilities and familiar with the design practices outlined in the Behavioral Health Design Guide (attached).

The firm will be responsible for engaging and coordinating an exceptional A/E Team experienced in the design of commercial office space and government facilities as related to this Project. The firm shall identify all the sub consultants recommended by the proposing firm to be members of the A/E Team and whose fees are included in the firm's fee proposal. The Center retains the right of review and approval of any such proposed sub consultants, based upon discussions with the firm and the Center.

RFP Timeline

Advertisement of Request for Proposals	February 25, 2022
Pre-proposal Meeting	March 21, 2022
Submittal of Questions	March 24, 2022
Responses to Questions Posted	April 1, 2022
Proposals Due	April 15, 2022
Interviews of Selected Proposals	May 2-6, 2022
Contract Award	May 26, 2022

Pre-Proposal Meeting

A required Pre-Proposal Meeting will be held on March 21, 2022 at 2:30 pm, virtually or otherwise stated by the Center.

Proposal Deadline

Sealed proposals are due no later than 10:00 am on April 15, 2022. Proposals will be unsealed at 4:00 pm the same day . Two electronic copies on separate USB flash drives and two bound copies of each document should be addressed to:

LifePath Systems
ATTN: Willy Villavicencio, Purchasing Manager
1515 Heritage Dr. Suite 203
McKinney, TX 75069
wvillavicencio@lifepathsystems.org

Project Milestone Schedule

Activities shown in bold below must have the associated dates identified and included with this Agreement and represent services to be performed by Project A/E pursuant to this Agreement. Supplemental activities shown on the schedule below, for which dates are not yet defined, shall be determined at the completion of the Pre-design Phase or at such time when both parties mutually agree that the project is sufficiently developed and documented.

Activity:	Completion Date:
Pre-design Phase	
Center Authorizes Project A/E to begin Pre-design Phase	May 27, 2022
Project A/E Submits Facility Program for Center Review	June 23, 2022
Joint Review Meeting for Center Comments	July 28, 2022
Project A/E Revises and Resubmits Facility Program	August 4, 2022
Center Approves Facility Program	August 12, 2022
Schematic Design Phase	
Center Authorizes Project A/E to Begin	August 18, 2022
Project A/E Submits SD Package for 95% Review	September 29, 2022
Joint Review Meeting for Center Comments	October 26, 2022
Center Approves Schematic Design	**November 10, 2022**
Design Development	
Center Authorizes Project A/E to Begin	November 11, 2022
Project A/E Submits DD Package for 95% Review	December 2, 2022
Joint Review Meeting for Center Comments	January 12, 2023
Center Approves Design Development	**January 26, 2023**
Board of Trustees Approval	*January 26, 2023*
Construction Documents Phase	
Center Authorizes Project A/E to Begin	January 27, 2023
Project A/E Submits CD Package for 50% Review	February 9, 2023
Joint Review Meeting for Center Comments	February 23, 2023
Project A/E Submits CD Package for 95% Review	March 16, 2023
Joint Review Meeting for Center Comments	April 6, 2023
Project A/E Submits CD Package for 100% Review	April 27, 2023
Joint Review Meeting for Center Comments	May 18, 2023
Center Approves 100% Construction Documents	**May 25, 2023**
Construction Phase Activities	
Commencement (Construction Start) Date	June 1, 2023
Substantial Completion	July 2024

Fee Matrix

The following is a guide for splitting the A/E fee into sections for each phase of work. Although it is not intended to be absolute, significant deviations should be closely reviewed. The intent of the guidelines is to ensure that design requirements progress in an orderly manner and that essential planning and system development occur when most beneficial to the project. Essential elements of the work should be completed and approved prior to initiating succeeding design phases. For a more detailed explanation of activities normally included in each phase, see the Scope of Project section.

Phase	**Estimated Fee Amount**
Schematic Design	$_____.
Design Development	$_____.
Construction Documents	$_____.
Basic Services Fee	$_____.
Additional Services Fee	$_____.
Estimated-Totals	**$_____.**

Attach a detailed summary included in your Basic Services Fee, as well as including any additional supporting information as appropriate for requested estimated costs. (e.g. for Additional Services to be compensated on an hourly-rate basis include schedule of personnel for Project A/E and each consultant who provided the service, the hourly rate, and proposed the time expended. For Reimbursable Expenses, provide additional information as appropriate to the project.

Proposal Instructions and Format

Along with a copy of your standard contract, which will be subject to review, negotiation and possible revision, please include the following items in any Proposal submitted in response to this RFP:

1. Firm name, address, phone, and email.
2. Describe your firm's background, ownership of your firm and list its principal shareholders.
3. Describe your firm and how it is organized including its overall size in numbers of employees.
4. Describe the practicing ideas or themes that serve as the central organizing elements of your firm's architectural practice as related to the construction of commercial office space and government facilities.
5. Provide names and resumes of key personnel who would be directly responsible for the work. Please include in resumes only projects related to commercial office space and government facilities, firm worked for, and project title/responsibility.
6. Please submit key reference contact information including telephone numbers, fax numbers and email addresses.
7. Submit an organizational chart for the entire recommended A/E Team as referenced in item 3 above.
8. Provide a complete list of your firm's commercial office space and government facilities that were constructed during the last 5 years or currently under construction. Please include:
    - Project name
    - Project location
    - Contracting or ownership entity
    - Project description listing dates of design, project gross square footage, construction cost and total design fee (including sub- consultants).

Provide a certificate of insurance showing coverages for general liability, automobile liability, worker's compensation, and professional liability.

9. Describe the process by which you will develop alternative schematic designs for a typical project.
10. Describe your approach to project design that will assure the functional, aesthetic and quality requirements are satisfactorily addressed for new construction.
11. Explain the management tools, techniques, and procedures your team uses to maintain the programming, planning and design phase schedule.
12. Explain your team's procedures for documenting quality control and coordination of the various disciplines of work in preparing construction documents.
13. Explain the design team's use of whole building energy analysis (including life cycle cost analyses) to assure the building is energy efficient.
14. Describe your team's approach to maintenance considerations in the design process.
15. Explain how your team will control project cost to assure the project budget is not exceeded.
16. Explain how your firm ensures compliance with the Americans with Disabilities Act (ADA). Provide examples.

17. Describe in detail the process you will follow from schematic approval through approval of final design.

18. Explain why you believe your team is the most qualified firm to provide the requested services for this Project.

Your response may also contain any narrative, charts, tables, diagrams, or other materials in addition to those called herein; to the extent such additions are useful for clarity or completeness of the response. Attachments should clearly indicate on each page the paragraph in the RFP to which they pertain. The Center will not be liable for any errors in your proposals.

No modifications to your proposal will be accepted except during negotiations initiated by the Center.

The request for proposals and potential inclusion into the interview process shall in no way be deemed to create a binding contract or agreement between the respondent and the Center. Upon recommendation of the firm, the Center will enter into an agreement. If the Center and successful respondent are unable to reach agreement upon a contract, the Center reserves the right to immediately enter into negotiation and agreement with another respondent.

Each respondent submitting a Proposal in response to this RFP acknowledges and agrees that the preparation of all materials for submittal to the Center and all presentation, related costs, and travel expenses are the respondents' sole expense as the Center shall not, under any circumstances, be responsible for any cost or expense by the respondent.

The Center shall be allowed to keep any and all materials submitted by the respondents in regard to this RFP. Each respondent agrees to hold the Center harmless against any expenses, damages, and claims arising from or connected with your proposal, including patent, trademarks, copyright, or other intellectual property infringement or misappropriation.

Any media request of the respondents shall be concurrently directed to the Center during the receipt, analysis, selection, and subsequent contract negotiation until said contract is signed and delivered by the Center.

The Center reserves the right to accept or reject any or all proposals, to alter the selection process in anyway, to postpone the selection process for either party's own convenience at any time, and to waive any defects in proposals submitted. The Center reserves the right to issue addenda to this RFP at any time due to the need for clarification, change in schedule, or other reasons the parties so decide. The Center reserves the right to accept or reject any individual sub-consultants that the successful respondent proposes to use.

Your proposal constitutes an offer that remains open and irrevocable for a period of no less than 120 days unless your proposal states otherwise. Proposals after the award are public documents.

Selection Criteria

The Center will use a combination of criteria in the evaluation process, including, without limitation, overall qualifications, relevant experience with comparable facilities, references, proposed fee structures and such others as the Center may use in its sole discretion. The following criteria will be the basis on which firms will be selected for further consideration:

1. Specialized, appropriate expertise for this type of project.
2. Demonstration of best value for the project.
2. Organizational chart and project team expertise.
3. Proposed design approach and innovative design solutions for projects of this type.
4. Project quality control plan including recent experience with cost control, change orders, and maintaining design and construction schedules.
5. Current workload of firm's personnel vs. the Center's strict and urgent Project Milestone Schedule.
6. Record of successfully completed projects without major legal or technical problems.
7. Capabilities and proven experience in extensive evaluation of facilities energy consumption and life cycle analyses during design of similar projects.
8. Compliance with proposal format requirements.
9. Proximity to and familiarity with McKinney, Collin County, TX area.
10. Other factors that may be appropriate for the project.

The Center will review and create a short list of the number of firms to be interviewed. Those firms that are invited to interview will be expected to have the key project personnel available for presentation and interview between May 2-6, 2022. Times for individual interviews will be announced later but respondents will tentatively be provided a block of 2 hours for presentation and questions. Representatives for the Center will be in attendance for the interviews. Interviews will be conducted virtually, unless otherwise stated by the Center. The Center's representatives will recommend the successful respondent and will award a contract at or after the regularly scheduled Board of Trustees meeting on May 26, 2022.

Assurances, Certifications, Exhibits and Attachments

Vendor must submit the Assurance and Certifications and all Attachments requested, to include:

Vendor will submit a copy of their standard contract, along with proposal. Label this **(Attachment A.)**

Signature Page **(Attachment B)**

Resident/Non-Resident Certification **(Attachment C)**

Assurances Document **(Attachment D)**

Conflict of Interest Questionnaire **(Attachment E)**

Vendor shall review **Texas Administrative Code §412.54(c)** and provide a written response signed by Authorized Individual **(Attachment F)**

Vendor shall review **Texas Health and Safety Code §250.006** and provide a written response signed by Authorized Individual **(Attachment G)**

Form W-9 **(Attachment H)**

Lobbying Certification **(Attachment I)**

Deviation Form **(Attachment J)**

Vendor Questionnaire (REQUIRED)

Questions or Inquires

All questions must be submitted electronically no later than 4:00 pm on March 24, 2022.

LifePath Systems
Willy Villavicencio, Purchasing Manager
Email: wvillavicencio@lifepathsystems.org

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Prepared and distributed by the

LifePath Systems Purchasing Department

ATTACHMENT B

SIGNATURE PAGE

The attached proposal application is being submitted in response to the Architectural & Engineering Services A/E-RFP# 02-2022. The proposal is a firm offer and shall remain an open offer, valid for one hundred and eighty (180) days from the date of this document.

LifePath in its sole and absolute discretion shall have the right to award contracts for any or all materials listed in each proposal, shall have the right to reject any and all proposals and shall not be bound to accept the lowest proposal and shall be allowed to accept the total proposal of any one vendor. I understand that this proposal will be reviewed and evaluated according to the procedures indicated in this RFP.

_____	_____
Authorized Signature	Company Name
_____	_____
Typed or Printed Name	Street Address
_____	_____
Title	City, State, Zip Code
_____	_____
Telephone Number	Fax Number
_____	
Email	

ATTACHMENT C

RESIDENT/NON-RESIDENT CERTIFICATION

Contractor must answer the following questions in accordance with the Texas Government Code §2252.002, as amended:

A. Is the Contractor that is making and submitting this bid a "resident Contractor" or a "non-resident Contractor"?

Answer: _____Resident Contractor _____Non-resident Contractor

(1) Texas Resident Contractor - A Contractor whose principal place of business is in Texas and includes a Contractor whose ultimate parent company or majority owner has its principal place of business in Texas.

(2) Nonresident Contractor - A Contractor who is not a Texas Resident Contractor.

B. If the Contractor is a "Non-resident Contractor", does the state in which the Nonresident Contractor's principal place of business is located have a law requiring a Nonresident Contractor of that state to bid a certain amount or percentage under the bid of a Resident Contractor of that state in order for the nonresident Contractor of that state to be awarded a contract on his bid in such state?

Answer: _____Yes _____No Which state? _____

C. If the answer to Question B is "yes", then what amount or percentage must a Texas Resident Contractor bid under the bid price of a Resident Contractor of that state in order to be awarded a contract on such bid in said state?

Answer: _____

ATTACHMENT D
ASSURANCES DOCUMENT

The firm assures the following:

1. All addenda and attachments to the RFP as distributed by the Local Authority and designated by the checklist have been received.
2. No attempt has been or will be made by the firm to induce any person or firm to submit or not to submit a Proposal, unless so described in its Proposal.
3. The firm does not discriminate in its services or employment practices on the basis of race, color, genetic information, religion, sex, national origin, disability, veteran status, or age.
4. All cost and pricing information is reflected in the RFP response documents or attachments.
5. The firm accepts the terms, conditions, criteria, and requirements set forth in the RFP.
6. The firm accepts the Center's right to cancel the RFP at any time prior to Contract award.
7. The firm accepts the Local Authority's right to alter the timetables for procurement that are set forth in the RFP.
8. The Proposal submitted by the firm has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
9. Unless otherwise required by law, the information in the Proposal submitted by the firm has not been knowingly disclosed by the firm to any other firm prior to the notice of intent to award.
10. No claim will be made for payment to cover costs incurred in the preparation of the submission of the Proposal or any other associated costs.
11. Local Authority has the right to complete background checks and verify information.
12. The individual(s) signing this document and any Contract awarded to firm is authorized to legally bind the firm.
13. No employee of the Local Authority and no member of the Local Authority's Board will directly or indirectly receive any pecuniary interest from an award of the proposed Contract to firm. If the firm is unable to make the affirmation, then the firm must disclose any knowledge of such interests. See Attachment F.
14. The firm is not currently held in abeyance or barred from the award of a federal or state contract.
15. The firm is not currently delinquent in its payments of any franchise tax or state tax owed to the state of Texas, pursuant to Texas Business Corporation Act, Texas Civil Statutes) Article 2.45.
16. The firm shall disclose whether any of the directors or personnel of Proposer has either been an employee or a trustee of Local Authority within the past two (2) years preceding the date of submission of the Proposal. If such employment has existed, or at term of office served, the Proposal shall state in an attached writing the nature and time of the affiliations as defined. See Attachment F.
17. The firm shall identify in an attached writing any trustee or employee of Local Authority who has a financial interest in the firm or who is related within the second degree by consanguinity or affinity to a person having such financial interest. Such disclosure shall include a complete statement of the nature of such financial interest and the relationship, if applicable. See Attachment F.
18. No former employee or officer of the Local Authority directly or indirectly aided or attempted to aid in procurement of firm's service.

19. The firm shall disclose in an attached writing the name of every Local Authority employee and/or member of Local Authority's board with whom the firm is doing business or has done business during the 365-day period immediately prior to the date on which the Proposal is due. Failure to include such a disclosure will be a binding representation by firm that the natural person executing the Proposal has no knowledge of any key persons with whom the firm is doing business or has done business during the 365 day period prior to the immediate date on which the Proposal is due. See Attachment F.

20. Under Section 231.006, Family Code, the vendor, or applicant certifies that the individual or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated, and payment may be withheld if this certification is inaccurate. For purposes of the foregoing sentence, "vendor or applicant" shall mean firm; contract, bid or application shall mean the Proposal; and 'this contract" shall mean any Contract awarded to the Successful firm(s).

_____ _____

Signature of Applicant or Applicant's Authorized Representative Date

_____

Printed Name

_____

Title (if applicable)

ATTACHMENT E
CONFLICT OF INTEREST QUESTIONNAIRE

Please retrieve CIQ Form from the following website:
https://www.ethics.state.tx.us/data/forms/conflict/CIQ.pdf
(Attach completed CIQ Form as part of your proposal)

A signature is required in Box 7 regardless of any other entry on the form.

ATTACHMENT F
DISCLOSURE OF KINSHIP
Pursuant to the Texas Administrative Code §412.54(c)

ATTACHMENT G
NOTICE OF FELONY CONVICTION
Pursuant to the Texas Health and Safety Code §250.006

ATTACHMENT H
FORM W-9
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION
Vendors are to complete a W-9 Form and submit with Proposal Documents.

http://www.irs.gov/pub/irs-pdf/fw9.pdf

ATTACHMENT I
LOBBYING CERTIFICATION

The undersigned certifies, to the best of his or her knowledge and belief that:

1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress an officer or employee of Congress or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____ _____

Signature Date

_____

Print Name of Authorized Individual

_____

Title of Authorized Individual

_____

Organization Name

ATTACHMENT J
DEVIATION FORM

All deviations to this RFP must be noted on this sheet. In the absence of any entry on this Deviation Form, the prospective firm assures LifePath of their full agreement and compliance with the Specifications and Terms and Conditions.

Each response to this RFP shall contain a Deviation Form, which states the prospective Vendor's commitment to the provisions of the RFP. An individual authorized to execute contracts must sign the Deviation Form. Any exceptions taken to the terms and conditions identified in this Proposal must be expressly stated in the Deviation Form. Use an additional copy or page if needed.

THIS DEVIATION FORM MUST BE SIGNED AND SUBMITTED WITH THE RFP BY EACH PROSPECTIVE VENDOR/CONTRACTOR WHETHER THERE ARE DEVIATIONS LISTED OR NOT. IF NO DEVIATIONS, NOTE: NONE

Reference Specifications, Terms and Conditions and Page Number	Deviation

_____
Company Name

_____ _____
Authorized Signature Date

NOTICE "NOT TO PARTICIPATE" FORM

Dear Vendor:

Please check the appropriate box below, complete the remainder of this form and return it PRIOR to the scheduled due date and time on the Proposal.

□ Our Company cannot provide the products, supplies and/or services listed in this request. Please MOVE our name and address to the following services so that we may submit bids/proposal at a later date:

Services:

_____

□ Our Company has chosen NOT to submit a Proposal at this time but would like to remain on your list for this Proposal category. We did not submit a Proposal because:

Reason:

_____

□ Please REMOVE our Company name from all LifePath Systems lists until further notice.

Reason:

_____

Company Name: _____

Representative (printed):_____ Title:

_____

Address:_____ Phone:

_____

Email:_____Fax_____Other:

_____

****

****** Authorized Signature:

_____

Title:_____ Date: _____

A/E Questionnaire (REQUIRED)

1. Firm Name:

2. Address:

3. Tax Payer ID #:

4. E-mail Address:

5. Web Address:

6. Telephone: Fax:

7. Other Locations:

8. Organization Class: Individual ☐ Partnership ☐
Corporation ☐
Association ☐

9. Date Established:

10. Former Business Name:

11. Date of Dissolution:

12. Subsidiary of:

13. Historically Underutilized Business Information: HUB? Yes ☐ No ☐
Black American ☐ Hispanic American ☐
Native American ☐ American Woman ☐
Other (specify)

14. Principals & Officers: (Names & Responsibilities: Management, Design, Production, Specification, Development)

Name	Responsibility	Name	Responsibility

15. Key Personnel & Responsibilities:

Name	Responsibility

16. Number of Personnel by Discipline*:

Discipline	Number	Number Registered	Discipline	Number	Number Registered
Administration			Interior Arch		
Architects			Civil		
Landscape Arch			Environmental		
Planning			Drafting		
Programming			Inspection		
Structural			Other (specify)		
Mechanical					
Electrical					
HVAC			Net Total:		

****Respondent must be registered/licensed or have personnel on direct staff that are registered/licensed in at least one of the professional services discipline required to perform the services requested in this RFP. Professional Services are defined in TGC 2254.002(A) (2).**

17. Services Provided by Firm: (Please Check)

Administration	☐	Architectural	☐	Drafting	☐	Inspection	☐
Interior Arch	☐	Landscape Arch	☐	Planning	☐	Programming	☐
Structural	☐	Mechanical	☐	Electrical	☐	HVAC	☐

Civil ☐ Other (specify):

18. Professional Liability Coverage Errors & Omissions, etc.: Yes ☐ No ☐

Amount:

19. Services Provided through Consultant (Please Check):

Administration	☐	Architectural	☐	Drafting	☐	Inspection	☐
Interior Arch	☐	Landscape Arch	☐	Planning	☐	Programming	☐
Structural	☐	Mechanical	☐	Electrical	☐	HVAC	☐
Civil	☐	Other (specify):					

Name of Consultants Address

20. Geographical Limits:

21. Work Type Distribution by Proportion of Annual Average:

Work Type (Facility Use)	% by Fee	% by No. of Projects
Commercial, Office, Retail		
Industrial		
Educational		
Medical		
Other Institutional		
Other (specify)		
Type:		
New Building Design		
Restoration		
Renovation		

Interior Design

Urban or Site Planning

Prime Engineering

Other (specify)

22. Projects in Last Five Years: See Attached

23. Date of Questionnaire:

24.
Preparer

Name:

Title:

Signature:

Schedule Compliance

5 most relevant completed projects

	Design Phases				
Insert Name of Project Here Contract Completion Date Actual Completion Date	Study/ Analysis	Preliminary Design	Design	Working Drawings	
Explanatory Note					

	Design Phases				
Insert Name of Project Here Contract Completion Date Actual Completion Date	Study/ Analysis	Preliminary Design	Design	Working Drawings	
Explanatory Note					

	Design Phases				
Insert Name of Project Here Contract Completion Date Actual Completion Date	Study/ Analysis	Preliminary Design	Design	Working Drawings	
Explanatory Note					

Insert Name of Project Here Contract Completion Date Actual Completion Date	Design Phases Study/ Analysis — Preliminary Design — Design — Working Drawings	
Explanatory Note		

Insert Name of Project Here Contract Completion Date Actual Completion Date	Design Phases Study/ Analysis — Preliminary Design — Design — Working Drawings	
Explanatory Note		

Budget Compliance

5 most relevant completed projects

Insert Name of Project Here			Comments:
Owner's Budget	$	-	
A/E Cost Estimate	$	-	
Successful Respondent Amount	$	-	
Difference Between Initial Owner Budget and Contract Award	$	-	
Insert Name of Project Here			Comments:
Owner's Budget	$	-	
A/E Cost Estimate	$	-	
Successful Respondent Amount	$	-	
Difference Between Initial Owner Budget and Contract Award	$	-	
Insert Name of Project Here			Comments:
Owner's Budget	$	-	
A/E Cost Estimate	$	-	
Successful Respondent Amount	$	-	
Difference Between Initial Owner Budget and Contract Award	$	-	
Insert Name of Project Here			Comments:
Owner's Budget	$	-	
A/E Cost Estimate	$	-	
Successful Respondent Amount	$	-	
Difference Between Initial Owner Budget and Contract Award	$	-	
Insert Name of Project Here			Comments:
Owner's Budget	$	-	
A/E Cost Estimate	$	-	

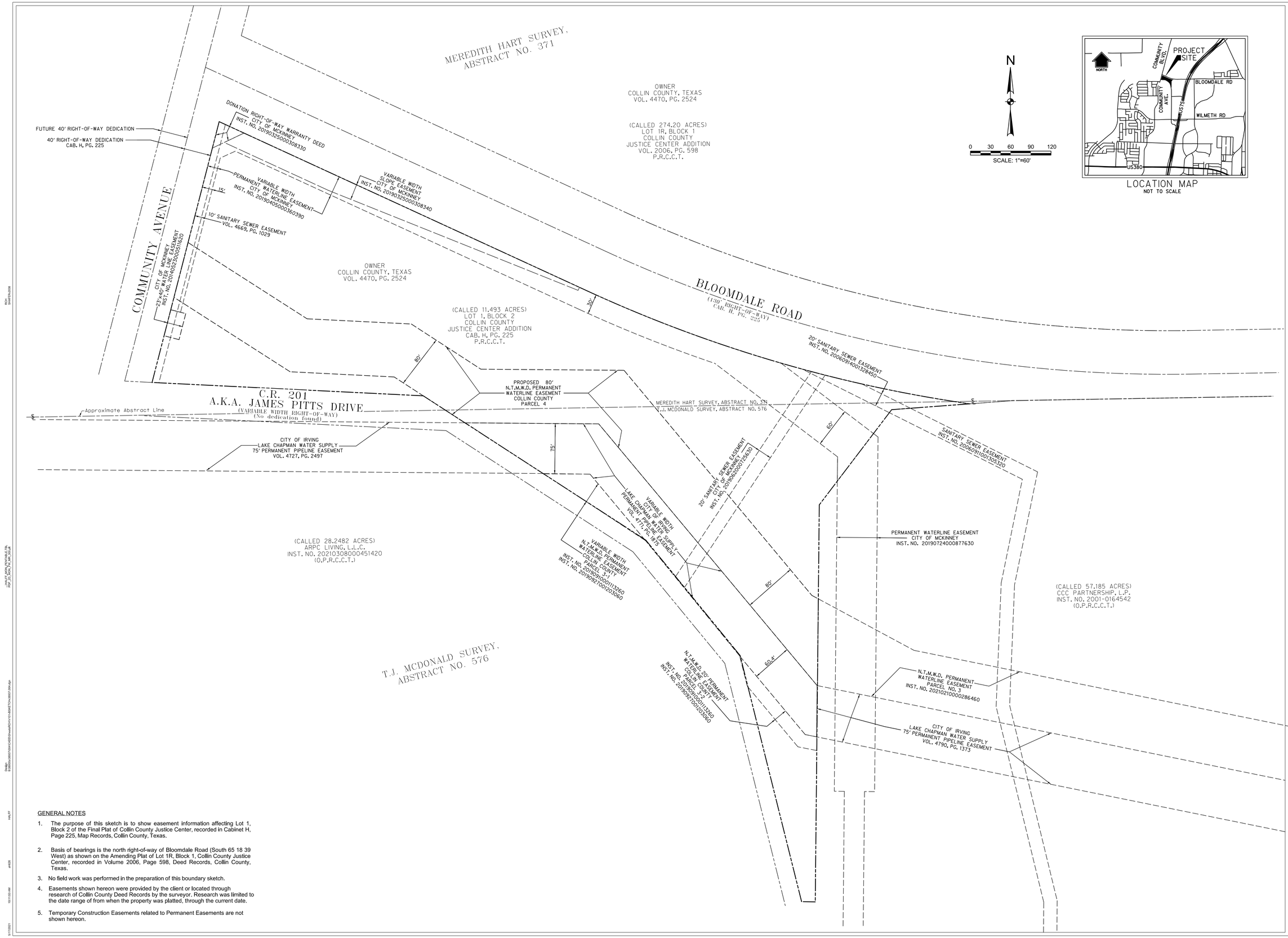
Successful Respondent Amount	$	-
Difference Between Initial Owner Budget and Contract Award	$	-

VENDORS WHO RESPOND TO THIS INVITATION WITH A COMPLETED PROPOSAL FORM WILL REMAIN ON OUR MAILING LIST. VENDORS MAKING NO RESPONSE MAY BE REMOVED FROM THE MAILING LIST.

PLEASE RETURN THIS FORM ONLY TO:

LifePath Systems
Willy Villavicencio, Purchasing Manager
wvillavicencio@lifepathsystems.org

Notice "Not to Participate" A/E-RFP#02-2022 Architectural & Engineering Services



LOCATION MAP
NOT TO SCALE

GENERAL NOTES

1. The purpose of this sketch is to show easement information affecting Lot 1, Block 2 of the Final Plat of Collin County Justice Center, recorded in Cabinet H, Page 225, Map Records, Collin County, Texas.
2. Basis of bearings is the north right-of-way of Bloomdale Road (South 65 18 39 West) as shown on the Amending Plat of Lot 1R, Block 1, Collin County Justice Center, recorded in Volume 2006, Page 598, Deed Records, Collin County, Texas.
3. No field work was performed in the preparation of this boundary sketch.
4. Easements shown hereon were provided by the client or located through research of Collin County Deed Records by the surveyor. Research was limited to the date range of from when the property was platted, through the current date.
5. Temporary Construction Easements related to Permanent Easements are not shown hereon.

BOUNDARY SKETCH

LOT 1, BLOCK 2

COLLIN COUNTY JUSTICE CENTER ADDITION
IN THE
CITY OF MCKINNEY, TEXAS
FOR
COLLIN COUNTY, TEXAS

HALFF
1201 NORTH BOWSER ROAD
RICHARDSON, TX 75081-2275
(214) 346-6200

Revision No.	Date	Description

Project No.:	38937.004
Issued:	05 / 17 / 2021
Drawn By:	WO
Checked By:	AS
Scale:	1"=60'

Sheet Title

BOUNDARY SKETCH

1 of 1

Sheet Number

Information Item V

Definitions

Adolescent - An individual at least 13 years of age, but younger than 18 years of age.

Adult Caregiver - An adult person whom a parent has authorized to provide temporary care for a child, as defined in Texas Family Code §34.0015(1).

Assessment - A systematic process for measuring an individual's service needs.

Certified Peer Specialist (CPS) - A person who uses lived experience, in addition to skills learned in formal training, to deliver strengths-based, person-centered services to promote an individual's recovery and resiliency as defined in 15 Texas Administrative Code (TAC), Subchapter N, §354.3003 (relating to Definitions).

Child - An individual at least 3 years of age, but younger than 13 years of age.

Community Services Specialist (CSSP) – As defined by 26 TAC Subchapter G, §301.303 (relating to Definitions) a staff member who:

a. received:
   i. high school diploma; or
   ii. high school equivalency certificate issued in accordance with the law of the issuing state;
b. had three continuous years of documented full-time experience in the provision of mental health rehabilitative services or case management services; and
c. demonstrated competency in the provision and documentation of mental health rehabilitative or case management services in accordance with 26 TAC, Chapter 306, Subchapter F of this title (relating to Mental Health Rehabilitative Services) and 26 TAC, Chapter 306 Subchapter F of this title (relating to Mental Health Case Management Services).

Continuity of care – As defined in 26 TAC Subchapter D, §306.153 (relating to Definitions) activities designed to ensure an individual is provided uninterrupted services during a transition between inpatient and outpatient services that assist the individual and the individual's LAR in identifying, accessing, and coordinating a local mental or behavioral

health authority (LMHA or LBHA) service and other appropriate services and supports in the community needed by the individual including:

a. assisting with admissions and discharges;
b. facilitating access to appropriate services and supports in the community, including identifying and connecting the individual with community resources, and coordinating the provision of services;
c. participating in the developing and reviewing individual's recovery or treatment plan;
d. promoting implementation of the individual's recovery or treatment plan; and
e. coordinating notification of continuity of care services between the individual and the individual's family and any other person providing support as authorized but the individual, and LAR if any.

Crisis – As defined by 26 TAC Subchapter G, §301.303 (relating to Definitions) a situation in which:

a. the individual presents an immediate danger to self or others; or
b. the individual's mental or physical health is at risk of serious deterioration; or
c. an individual believes that he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.

Crisis false-alarm – A designation (GJ modifier) for crisis hotline calls that require routine follow up and are not emergent or urgent. These calls do not require the use of MCOT activation.

Crisis Stabilization Unit (CSU) – a crisis stabilization unit providing short-term residential treatment 24 hours a day, every day of the year, in a secure and protected treatment environment licensed in accordance with Texas Health and Safety Code Chapter 577 (relating to Private Mental Hospitals and Other Mental Health Facilities)

a. CSU services are provided by medical personnel, mental health professionals, and trained support staff with documented competency in the provision of crisis services designed to reduce an individual's acute mental health symptoms.
b. CSU services are provided in accordance with standards in 26 TAC, Chapter 306, Subchapter B (relating to Standards of Care in Crisis Stabilization Units) and 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards).

Crisis Support Staff – A staff member who is not a licensed professional or a fully qualified professional but is delegated tasks within the healthcare system. This person has crisis training appropriate to the context they are working in and must have, at minimum, a high school diploma or its equivalent.

Crisis Treatment Plan - An individualized plan that develops and implements the most effective, and least restrictive, available crisis services necessary to stabilize the crisis episode. Used for EOU and Crisis Residential and Respite. The crisis treatment plan must:

a. Be developed by a staff credentialed, at minimum as a QMHP-CS
b. Be based on the individual's provisional psychiatric diagnosis; and
c. Incorporate, to the maximum extent possible, individual preferences

Declaration for Mental Health Treatment – A legal document that allows an individual to make decisions in advance (advanced directive) about specific mental health treatments related to psychoactive medication, convulsive therapy and emergency mental health treatment. The instructions an individual includes in this declaration will be followed only if a court believes that an individual is incapacitated to make treatment decisions. Otherwise, an individual will be considered able to give or withhold consent for the treatments noted above.

Developmental Disability (DD) – A severe, chronic disability attributable to mental or physical impairment or a combination of mental and physical impairments that:

a. manifests before an individual reaches 22 years of age;
b. is likely to continue indefinitely;
c. reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of a lifelong or extended duration and are individually planned and coordinated; and
d. results in substantial functional limitations in three or more of the following categories of major life activity:
    i. self-care;
    ii. receptive and expressive language;
    iii. learning;
    iv. mobility;
    v. self-direction;
    vi. capacity for independent living; and
    vii. economic self-sufficiency.

Emergency medical services - Services used to respond to an individual's perceived need for immediate medical care and to prevent death or aggravation of physiological or psychological illness or injury.

Emergency care services – As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) mental health community services or other necessary interventions directed to address the immediate needs of an individual in crisis to assure the safety of the individual and others who may be placed at risk by the individual's behaviors, including, but not limited to, psychiatric evaluations, administration of medications, hospitalization, stabilization, or resolution of the crisis.

General Residential Operation – A residential child-care operation that provides child care for 13 or more children or young adults according to 26 TAC Chapter 748, Subchapter B (relating to Definitions and Services). The care may include treatment services and/or programmatic services. These operations include formerly titled emergency shelters, operations providing basic child care, residential treatment centers, and halfway houses.

Inpatient Services – Services including medical, nursing, and mental health professionals providing 24-hour monitoring, supervision, and interventions designed to relieve acute psychiatric symptomatology and restore an individual's ability to function in a less restrictive setting. Inpatient units must comply with 26 TAC Chapter 568 (relating to Standards of Care and Treatment in Psychiatric Hospitals).

Individualized Crisis Treatment Plan - An individualized plan that develops and implements the most effective, and least restrictive, available crisis services necessary to stabilize the crisis episode. Used for MCOT and Walk-In Services. The individualized crisis treatment plan must:

a. Be developed by a staff credentialed, at minimum as a QMHP-CS
b. Be based on the individual's provisional psychiatric diagnosis; and
c. Incorporate, to the maximum extent possible, individual preferences

Intellectual Disability (ID) - Significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period, which is before the age 18.

Legally Authorized Representative (LAR) – A person authorized by law to act on behalf of an individual about a matter described in this subchapter, including, but not limited to, a parent, guardian, or managing conservator.

Local Intellectual and Developmental Disability Authority (LIDDA) – As defined 26 TAC Subchapter C §307.105 (relating to Definitions) an entity designated as the local intellectual and developmental disability authority by the Health and Human Services Commission (HHSC) in accordance with Texas Health and Safety Code §533.0356.

Local Behavioral Health Authority (LBHA)- As defined 26 TAC Subchapter C §307.105 (relating to Definitions) an entity designated as the local mental health authority by the HHSC in accordance with Texas Health and Safety Code §533.0356

Local Mental Health Authority (LMHA) - As defined 26 TAC Subchapter G §301.303 (relating to Definitions) an entity designated as the local mental health authority by the HHSC in accordance with Texas Health and Safety Code §533.035(a).

Licensed Professional of the Healing Arts (LPHA) – As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) a staff member who is:

a. a physician;
b. a licensed professional counselor;
c. a licensed clinical social worker;
d. a licensed psychologist;
e. an advanced practice nurse; or
f. a licensed marriage and family therapist.

Medical Necessity – As defined in 26 TAC Subchapter F, §306.305 (relating to Definitions) a clinical determination made by an LPHA that services:

a. are reasonable and necessary for the treatment of a serious mental illness; or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
b. are provided in accordance with accepted standards of practice in behavioral health care;
c. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
d. are at the most appropriate level or amount of service that can be safely provided; and
e. could not have been omitted without adversely affecting the individual's mental or physical health or the quality of care rendered.

Mobile Crisis Outreach Team (MCOT) – Qualified professionals deployed into the community to provide a combination of crisis services including facilitation of emergency care services and provision of urgent care services, crisis follow-up, and relapse prevention to children, adolescents, or adults 24 hours a day, every day of the year.

On call - The Code of Federal Regulation Fail Labor Standard Act states an employee is on standby duty or on-call status if the employee is restricted by official order to a designated post of duty and is assigned to be in a state of readiness to perform work with limitations on the employee's activities so substantial that the employee cannot use the time effectively for his or her own purposes.

On duty – A period of time when an LMHA/LBHA employee is on the employer's premises or at any other prescribed place of work, from the beginning of the first principal activity of the work day to the end of the last principal work activity of the workday.

Outpatient, Screening, and Assessment and Referral Services (OSAR) – A service available to individuals interested in information about substance use services. OSAR Services are incorporated into LMHAs and LBHAs across the 11 Texas Health and Human Services Regions. The only requirement for service is that an individual is currently residing in the state of Texas.

Person-centered recovery plan – As defined in 1 TAC Subchapter N, §354.3003 (relating to A written plan that serves as a plan of care and:

a. is developed with the person, others whose inclusion is requested by the person and who agree to participate, and the persons planning or providing services;
b. amended at any time based on the person's needs;
c. guides the recovery process and fosters resiliency;
d. identifies the person's changing strengths, capacities, goals, preferences, needs, and desired outcomes; and
e. identifies services and supports to meet the person's goals, preferences, needs and desired outcomes.

Psychiatric Emergency Services Center (PESC) - A psychiatric emergency services facility that provides walk-in access to immediate behavioral health emergency screening and assessment, extended observation services, and a continuum of crisis and behavioral emergency stabilizing treatment for individuals whose behavioral symptoms cannot be stabilized within 48 hours. A PESC must provide a combination of services that includes, at minimum:

a. Extended Observation services, as described in Information Item V.IV. Extended Observation Unit A. Description, in a designated area of the PESC; and
b. Inpatient services in an environment designed to provide safety and security during acute behavioral health crisis; or
c. CSU services in a secure and protected treatment environment that complies with CSU licensure requirements.

Qualified Mental Health Professional-Community Services (QMHP-CS) – As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) a staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:

a. has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA, LBHA, or Managed Care Organization in accordance with 26 TAC Chapter 301, Subchapter G of this title (relating to Competency and Credentialing) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
b. is a registered nurse; or
c. completes an alternative credentialing process identified by the department.

Routine Care Services - As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) mental health community services provided to an individual who is not in crisis.

Rural – a county with less than 250,000 residents.

Screening - As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) activities performed by a QMHP-CS to gather triage information to determine the need for in-depth assessment. The QMHP-CS collects this information through face-to-face, or telephone or tele-health interviews with the individual or collateral.

Stock Inspection - A most recent stock and medication room inspection, including inventory of over the counter stock medication, inventory of client medications, controlled drug inventory, monitoring of the emergency medication kit, monitoring of medication expiration dates, and a medication room inspection, which includes monitoring of medication refrigerator temperature controls.

Substance Use Disorder – As defined by 15 TAC Subchapter N, §354.3003 (relating to Definitions) recurrent use of alcohol or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Telehealth - In accordance with Texas Occupation Code Chapter 111, and 22 TAC Subchapter B, §174.9 (relating to Mental Health Services), which allows provision of mental health services, a health service other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to an individual at a different physical location than the health professional using telecommunications or information technology, including:

a. compressed digital interactive video, audio, or data transmission;
b. clinical data transmission using computer imaging by way of still-image capture and store and forward; and
c. other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine - In accordance with Texas Occupations Code Chapter 111, and 22 TAC Subchapter B, §174.9 (relating to Mental Health Services), which allows provision of mental health services, a health care service delivered by a physician licensed in this stated or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to an individual at a different physical location than the physician or health professional using telecommunications or information technology, including:

a. compressed digital interactive video, audio, or data transmission;
b. clinical data transmission using computer imaging by way of still-image capture and store and forward; and
c. other technology that facilitates access to health care services or medical specialty expertise.

Urban – a county with a population of over 250,000 residents.

Urgent care services - As defined in 26 TAC Subchapter G, §301.303 (relating to Definitions) mental health community services or other necessary interventions provided to individuals in crisis who do not need emergency care services but who are potentially at risk of serious deterioration.

Crisis Service Standards

I. Hotline

A. Definition

A crisis hotline is continuously available telephone service staffed by trained and competent crisis staff to provide crisis screening and access to crisis intervention services, mental health and substance use referrals support, and general mental health and substance use information to callers 24 hours per day, seven days per week.

B. Goals

- Crisis resolution in the least restrictive environment
- Immediate telephone response to individuals for the purpose of linkage to appropriate services and follow-up

C. Description

In accordance with Texas Health and Safety Code (THSC) §534.053(a)(1) and 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) the crisis hotline is an integrated component of the overall crisis program; it operates continuously and is accessible toll-free throughout the local service area. Any entity providing crisis hotline services for any portion of the day must be accredited by the American Association of Suicidology (AAS).

The crisis hotline serves as an immediate point of contact for mental health and substance use crises in the community, providing confidential telephonic triage to determine the immediate level of need and to mobilize emergency services for the caller if necessary. The crisis hotline facilitates referrals to 911, mobile crisis outreach teams (MCOT), or other crisis services and conducts follow-up contacts to ensure callers successfully accessed the referred services. The initial screening leads to immediate and appropriate referrals, including OSAR. If an emergency is not evident after further screening or assessment, the crisis hotline includes referral to other appropriate resources within or outside the LMHA/LBHA. The crisis hotline works in close collaboration with local law enforcement and 211 and 911 systems.

D. Standards

1. Staffing

a. Community Services Specialist (CSSP) or Crisis Support Staff. A CSSP or crisis support staff may answer the crisis hotline and provide information and non-crisis

referrals for routine calls. In accordance with 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards), if the call is deemed emergent or urgent, then the CSSP or crisis support staff must refer to the QMHP-CS within one minute after the call is identified as such.

b. Peer Support Specialist. A Peer Support Specialist may answer the crisis hotline and provide peer services in accordance with 15 TAC, Chapter 354, Subchapter N (relating to Peer Specialist Services). If the call is deemed emergent or urgent, then the Peer Support Specialist must refer to the QMHP-CS within one minute after the call is identified as such if the staff is not also certified as a QMHP-CS.
c. QMHP-CS. A QMHP-CS is required to provide screening and assessment to determine the nature and seriousness of the call.
d. LPHA. A LPHA must be available for consultation 24 hours a day, in person or by telephone.
e. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

2. Training and Competency

a. Training. All QMHP-CSs responding to crisis calls are required to be trained and competent in all domains of the screening.
b. Evidence of crisis.
    i. If an emergency is evident after the screening, crisis hotline staff must facilitate referrals to the MCOT, or other emergency care or emergency medical services.
    ii. If an emergency is not evident, the crisis hotline staff must provide referrals to other appropriate resources within or outside the LMHA, LBHA, or LIDDA.

3. Crisis Hotline Screening Requirements

The crisis hotline is required to provide a thorough crisis screening and documentation that incorporates the following domains:

a. Suicide Risk Screening
    i. Suicidal ideation – documents the wish to be dead, non-specific active suicidal thoughts without thoughts of ways to kill oneself, active suicidal ideation with any methods without intent to act, active suicidal ideation with some intent to act but without a specific plan, current access to means, and active suicidal ideation with specific plan and intent.
    ii. Intensity of ideation – documents frequency, duration, controllability, deterrents, and reasons for ideation.
    iii. Suicidal behavior – documents actual attempts, non-suicidal self-injurious behaviors, interrupted attempts, aborted or self-interrupted attempts, preparatory acts or behaviors, actual and potential lethality of the most recent attempt, most lethal attempt, and the initial or first attempt.

b. Homicide Risk Screening
    i. Homicidal Ideation – documents the wish for another to be dead, non-specific active homicidal thoughts without thoughts of ways to kill another, active homicidal ideation with any methods without intent to act, active homicidal ideation with specific plan and intent.
    ii. Intensity of Ideation - documents frequency, duration, controllability, deterrents, and reasons for ideation.
    iii. Homicidal behavior – documents actual attempts, non-homicidal injurious behaviors, interrupted attempts, aborted or self-interrupted attempts, preparatory acts or behaviors, actual and potential lethality of the most recent attempt, most lethal attempt, and the initial or first attempt.
c. Risk of Deterioration Screening
    i. Documents any report of suffering from severe and abnormal mental, emotional, or physical distress;
    ii. Documents experiencing substantial mental or physical deterioration of the proposed individual's ability to function independently, which is exhibited by the proposed individual's inability, except for reasons of indigence, to provide for the proposed individual's basic needs, including food, clothing, health, or safety; and
    iii. Documents inability to make a rational and informed decision as to whether or not to submit to treatment.

4. Crisis Hotline Activation and Continuity

a. Screening Follow-Up and Activation in accordance with 26 TAC, Chapter 301 Subchapter G (relating to Mental Health Community Services Standards).
    i. If it is determined that an individual is experiencing a crisis that may require emergency care services, the QMHP-CS must:
        (1) Take immediate action to address the emergency situation to ensure the safety of all parties involved;
        (2) Activate the immediate screening and assessment processes, face to face in person or through telehealth or telemedicine, as described in 26 TAC, Chapter 301, Subchapter G (relating to Crisis Services); and
        (3) Provide or obtain mental health community services or other necessary interventions to stabilize the crisis.
    ii. If the screening indicates that an individual needs urgent care services, a QMHP-CS must, within eight hours of the initial incoming hotline call or notification of a potential crisis situation:
        (1) Perform an assessment face to face in person or through telehealth or telemedicine; and
        (2) Provide or obtain mental health community services or other necessary interventions to stabilize the crisis.
    iii. If the screening indicates that a call is a crisis false-alarm, the screener must document the call. Additionally, if the screening indicates that an individual needs routine care services and the individual does not decline services, a

QMHP-CS must perform a uniform assessment within 14 days after the screening.

b. Continuity of Services
   i. The crisis hotline determines the individual's initial level of risk (i.e. emergent, urgent, or routine); and if MCOT is called to respond to the crisis, the response time frame is established by the QMHP-CS who conducted the crisis hotline screening.
   ii. Continuity of services must be provided by the LMHA or LBHA upon the completion of the screening or assessment to ensure uninterrupted treatment during a transition between services.

5. Accreditation and Scoring Requirements

a. The phone line providing crisis hotline services must be accredited by AAS and integrated with the LMHA's or LBHA's local crisis response system, which includes MCOT as well as other services in the LMHA's or LBHA's crisis service array. LMHAs and LBHAs utilizing a subcontractor to provide crisis hotline services, must ensure that the subcontracting agency's crisis hotline maintains AAS accreditation.
b. The crisis hotline must also meet minimum scoring requirements outlined by HHSC under each area of the table below, excluding Lethality Assessment and Rescue Services in the 9th and 10th editions. A minimum component score of 2 is required and an area minimum score is required as shown below.
c. The LMHA or LBHA should use the edition of the AAS Organization Accreditation Standards Manual that is applicable to the year of accreditation.
d. If the LMHA or LBHA contracts with an outside entity to provide all or part of the crisis hotline service, the LMHA or LBHA or subcontractor must also be accredited by AAS, meet minimum scoring requirements (outlined below), and remain contractually responsible for compliance with the applicable standards.
e. Evidence of initial or continued accreditation by AAS must be submitted to HHSC per Information Item S within 30 days of receipt. Submission must include any report of accreditation review findings by AAS and LMHA or LBHA responses to these findings, if applicable.

Listed below are the minimum scores acceptable to meet HHSC standards in each area described in the 9th, 10th, 11th, 12th, and current 13th Edition of the AAS Organization Accreditation Standards Manual.

AREA	9th Ed MINIMUM SCORE	10th Ed MINIMUM SCORE	11th Ed MINIMUM SCORE	12th Ed MINIMUM SCORE	13th Ed MINIMUM SCORE
Administration and Organizational Structure	11	14	16	16	16

AREA	9th Ed MINIMUM SCORE	10th Ed MINIMUM SCORE	11th Ed MINIMUM SCORE	12th Ed MINIMUM SCORE	13th Ed MINIMUM SCORE
Training Program (8th ed)/ Screening, Training, and Monitoring Crisis Workers	16	16	16	16	16
General Service Delivery	16	16	16	16	16
Services in Life-Threatening Situations	8	8	8	8	8
Ethical Standards and Practice	13	13	13	13	13
Community Integration	9	9	9	9	9
Program Evaluation	10	10	10	10	10

II. Mobile Crisis Outreach Team

A. Definition

Mobile Crisis Outreach Teams (MCOTs) are qualified professionals deployed into the community to provide a combination of crisis services including facilitation of emergency care services and provision of urgent care services, crisis follow-up, and relapse prevention to children, adolescents, or adults 24 hours a day, every day of the year.

B. Goals

- Crisis resolution
- Linkage to appropriate services and follow-up
- Reduction of inpatient and law enforcement interventions
- Stabilization in the least restrictive environment
- Diversion from emergency rooms when possible

C. Description

An MCOT program consists of a roster of dedicated or rotating staff working in a team deployed into the community to provide crisis intervention services in compliance with 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards). MCOT services include emergency care, urgent care, crisis follow-up and relapse prevention to adults, children, and adolescents. MCOT staff coordinate with the crisis hotline and community partners to determine when and where crisis outreach services are needed in the community.

D. Standards

1. Staffing Standards

a. A psychiatrist must serve as the medical director for all crisis services and must approve all policies, procedures, and protocols used in crisis services.

b. Urban staffing requirements:

i. One LPHA and one QMHP-CS must be on duty 12 hours a day, every day of the week.

ii. One LPHA and one QMHP-CS must be on call 24 hours a day, every day of the week.

c. Rural staffing requirements:

i. Two QMHP-CS must be on duty eight hours a day, every day of the week.

ii. One LPHA and one QMHP-CS must be on call 24 hours a day, every day of the week.

d. The team must have licensed medical professionals, including a physician (preferably a psychiatrist), or a PA or APRN with specialized mental health training, or an RN, who are readily available for MCOT consultation, either in person, or through telephone, or video, 24 hours a day, every day of the year.

e. MCOT must deploy at least two staff members when clinically indicated.
f. When a Certified Peer Specialist deploys with the team, they must provide peer services in accordance with 15 TAC Subchapter N, §354.3013 (relating to Services Provided) and cannot conduct crisis screenings, assessments, or intervention.
g. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

2. Availability

a. MCOT services must be available 24 hours per day, every day of the year.
b. LMHAs and LBHAs must ensure policies and procedures identify peak hours and staffing patterns based on call volume and analysis of encounter data.
c. MCOT members must deploy in person or provide services through telehealth or telemedicine when a call is received.
d. Response time frames per 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) are:
    i. Emergent care. MCOT must respond, whether face to face in person or through telehealth or telemedicine, to emergent care events immediately but no later than one hour.
    ii. Urgent care. MCOT must respond, whether face to face in person or through telehealth or telemedicine, to urgent crises no later than eight hours.
    iii. Routine care. The LMHA or LBHA must perform a uniform assessment within 14 days after the screening, if individual does not decline services.
    iv. Follow up. Initial crisis follow-up and relapse prevention services must be provided within 24 hours of the initial call or contact.

3. Policies and Procedures

The LMHA or LBHA must develop and implement written policies and procedures that are approved by the medical director and must be consistent with evidence-based or best practices. Written policies and procedures must be submitted to HHSC in conjunction with the Consolidated Local Services Plan submission every two years. Policies and procedures must include the following:

a. Duties and responsibilities. To define the duties and responsibilities for all staff involved in the assessment or treatment of a crisis.
b. Staff training. To address staff training, competency, experience, and be consistent with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
c. Location of services provided. To ensure that services reach individuals where the crisis episode occurs or where the individual deems appropriate. At community locations like jails or emergency rooms that may provide intervention

services (medical, behavioral), MCOTs must still deploy or provide services through telehealth or telemedicine if they are called to provide crisis intervention services.

d. Law enforcement. To ensure that:
    i. MCOT requests for a member of law enforcement to meet MCOT and the individual at the location of the crisis when there is a significant level of risk to staff or the individual in crisis; and
    ii. Crisis assessments are completed by MCOT and not delegated to law enforcement, in accordance with 26 TAC §301.351(b)(1) (relating to Screening and assessment).
e. Transportation to MCOT recommended treatment. To ensure MCOTs provide linkages to alternate transportation services for individuals when the MCOT is unable to provide these services.
f. Behavioral health emergencies. To define the procedure for the most effective and least restrictive approaches to common behavioral health emergencies seen by MCOT. Policies must include procedures for:
    i. Communicating with inpatient psychiatric service providers when referring individuals into inpatient emergency services; and
    ii. Identifying alternate crisis service providers, and linking individuals to these providers, when MCOT is unable to respond to a crisis situation.
g. Reassessment. To define appropriate reassessment intervals in emergent, urgent, and routine care.

4. MCOT Duties and Responsibilities

a. Crisis training and competency. The LMHA or LBHA must define competency-based expectations for each staff position and implement a process to ensure competency of staff members prior to providing services. In accordance with 26 TAC §301.331 (relating to Competency and Credentialing) all MCOT staff must receive crisis training that includes at a minimum:
    i. Identifying signs, symptoms, and crisis response related to substance use;
    ii. Identifying signs, symptoms, and crisis response to trauma, abuse, and neglect;
    iii. Identifying signs, symptoms, and crisis response to individuals with intellectual disability and developmental disabilities;
    iv. Identifying specialized assessment and intervention strategies for children, adolescents, and families;
    v. Assessing individuals and providing intervention;
    vi. Conducting suicide screenings and assessments, homicide screenings and assessments, and risk of deterioration screenings and assessments;
    vii. Applying knowledge and effective use of communication strategies such as a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, according to 25 TAC, Chapter 415, Subchapter F (relating to Interventions in Mental Health Services);

viii. Completing clinical interviews in behavioral health crisis care for all clinical staff, including a physician (preferably a psychiatrist), Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), Physician's Assistant (PA), LPHA, or QMHP-CS; and

ix. Using telehealth or telemedicine technology, if applicable. Telemedicine and telehealth competencies must be included for positions in which a staff member's job duties are related to or involve assisting with telemedicine or telehealth services and include adequate and accurate knowledge of:
(1) operation of the telehealth or telemedicine equipment; and
(2) how to use the equipment to adequately present the individual.

b. Licensing, Credentialing, and Supervision. All MCOT team members must obtain and maintain licensing, credentialing, and supervision standards per their license, certification, or scope of practice that includes, but is not limited to:
i. Licensing in accordance with the respective chapter of the Texas Occupations Code;
ii. Credentialing in accordance with 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards);
iii. Supervision in accordance with the respective chapter of the Texas Occupations Code; and
iv. Certification in accordance with 1 TAC Chapter 354, Subchapter N (relating to Peer Specialist Services).

c. Location of Services. These services must be delivered at the location where the crisis occurred unless the individual, family member, adult care giver, or LAR expresses preference to another location. If a crisis presents in a community location, such as a jail or hospital, including an emergency department, MCOT must respond immediately, but in no longer than one hour, to an emergency care crisis or eight hours to an urgent care crisis. The LMHA or LBHA must provide services through telehealth or telemedicine or deploy MCOT to the location of the individual for subsequent contact or crisis follow-up and relapse prevention services in accordance with approved policies, procedures, and protocols.

5. Screening and Assessment

The LMHA or LBHA must develop and implement a written policy and procedure that for:

a. Crisis Screening. The written policy must describe the process for performing the screening. The process must address the criteria for requesting an immediate crisis assessment, medical screening and assessment, and psychiatric evaluation. A thorough crisis screening and documentation must incorporate the following domains:
i. Suicide Risk screening
(1) Suicidal ideation – documents: the wish to be dead, non-specific active suicidal thoughts without thoughts of ways to kill oneself; active suicidal ideation with any methods without intent to act, active suicidal ideation

with some intent to act but without a specific plan; current access to means; and active suicidal ideation with specific plan and intent.

(2) Intensity of ideation – documents: frequency; duration; controllability; deterrents; and reasons for ideation.

(3) Suicidal behavior – documents: actual attempts; non-suicidal self-injurious behaviors; interrupted attempts; aborted or self-interrupted attempts; preparatory acts or behaviors; actual and potential lethality of the most recent attempt; most lethal attempt; and the initial or first attempt.

ii. Homicide Risk Screening

(1) Homicidal Ideation – documents: the wish for another to be dead; non-specific active homicidal thoughts without thoughts of ways to kill another; active homicidal ideation with any methods without intent to act; active homicidal ideation with specific plan and intent.

(2) Intensity of Ideation – documents: frequency; duration; controllability; deterrents; and reasons for ideation.

(3) Homicidal behavior – documents: actual attempts; non-homicidal injurious behaviors; interrupted attempts; aborted or self-interrupted attempts; preparatory acts or behaviors; actual and potential lethality of the most recent attempt; most lethal attempt; and the initial or first attempt.

iii. Risk of Deterioration Screening

(1) Documents any report of experiencing severe and abnormal mental, emotional, or physical distress.

(2) Documents experiencing substantial mental or physical deterioration of the proposed individual's ability to function independently, which is exhibited by the proposed individual's inability, except for reasons of indigence, to provide for the proposed individual's basic needs, including food, clothing, health, or safety.

(3) Documents inability to make a rational and informed decision as to whether or not to submit to treatment.

b. Screening outcomes and dispatch levels. The crisis screening identifies the individual's level of risk, which determines the MCOT dispatch level (emergent, urgent, or routine) and protocol for crisis response, including crisis assessment. The original dispatch level from the screening may be changed, but only after information is reported that the individual is not able to participate in the screening or assessment due to:

i. Inaccessibility of their physical location;

ii. Level of cognitive impairment; or

iii. State of consciousness.

c. Response Procedures

i. Emergent - An MCOT informed of an emergent dispatch must:

(1) Respond immediately, or within one hour of the incoming crisis hotline call or notification of a potential crisis situation, to initiate the crisis response and assessment process as described in 26 TAC Chapter 301, Subchapter G of this title (relating to Mental Health Community Services Standards);

(2) Notify law enforcement with a request to co-respond with MCOT to secure the safety of all individuals present if an MCOT member believes their safety to be at risk when responding to a crisis in the community;
(3) Perform a face-to-face assessment in person or through telehealth or telemedicine services;
(4) Provide or obtain mental health community services or other necessary interventions to stabilize the crisis;
(5) Arrange for a physician (preferably a psychiatrist) to examine an individual face-to-face in person or through telemedicine, in accordance with 26 TAC Subchapter G, §301.351 (relating to Crisis Services), as soon as possible, but no later than 12 hours after the QMHP-CS's assessment, to determine the need for emergency services. MCOT will provide the receiving facility or service provider all relevant crisis documentation; and
(6) Develop an individualized crisis treatment plan including an intervention, outcome, follow-up plans, aftercare, and referral.

ii. Urgent - An MCOT informed of an urgent dispatch must:
(1) Respond within eight hours of the initial incoming crisis hotline call or notification of a potential crisis situation;
(2) Notify law enforcement to respond with MCOT, when possible, to secure the safety of all individuals present if an MCOT member believes their safety to be at risk when responding to a crisis in the community; Perform a face-to-face assessment in person or through telehealth or telemedicine services;
(3) Provide or obtain mental health community services or other necessary interventions to stabilize the crisis; and
(4) Develop an individualized crisis treatment plan including an intervention, outcome, follow-up plans, aftercare, and referral.

iii. Routine - If the screening indicates that an individual needs routine care services, a QMHP-CS must perform a uniform assessment within 14 days after the screening, in accordance with 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards), routine care services.

iv. MCOT, or other staff members providing crisis assessment, must document in the individual's health record justification for failing to dispatch or provide crisis response to an individual within the timeframes listed for emergent and urgent response.

d. Crisis assessment. A crisis assessment must be completed face-to-face, in person or through telehealth or telemedicine, in accordance with 26 TAC Subchapter G, §301.321 (b)(2). A crisis assessment must include historical and current information such as the following:

i. Mental health domain. Documents an individual's: symptomology; functionality; historical and current diagnoses and treatment for: mental health, serious emotional disturbance, or intellectual disability and developmental disorder diagnoses. The assessment must include:
(1) A review of records of the individual's past treatment (when available);

(2) History from collateral sources. The team must be proactive in gathering input or corroboration of events from family members, adult care givers, or LARs whenever possible. Every effort must be made to engage family, adult care givers, or LAR support around the individual in crisis while maintaining confidentiality;
(3) Contact with the individual's current healthcare providers whenever possible; and
(4) If available, a history of the individual's previous mental health, substance use, intellectual disability or developmental disability treatment that includes:
(a) A record of past psychiatric medication, dosages, response to medications, side effects and adherence;
(b) An up-to-date record of all medications currently prescribed and the name of the prescribing professional; and
(c) Identification of social, environmental, and cultural factors that may be contributing to the crisis;
(5) Attempt to determine if the individual has an active Declaration for Mental Health Treatment when interviewing the individual and the individual's collateral resources or current healthcare providers.

ii. Suicide domain. Documents an individual's: current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;
iii. Violence domain. Documents an individual's current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;
iv. Trauma, abuse, and neglect domain. Documents an individual's: current and past trauma or abuse and neglect; where the trauma or abuse and neglect was experienced; and how long the trauma or abuse and neglect occurred;
v. Substance use domain. Documents an individual's: current use and how their use affects their thoughts and behaviors regarding suicide and violence; the last time of use; the history of substance use and recovery status; history of use, abuse, or overdose on alcohol, drugs, medications, or other substances;
vi. Physical and cognitive health domain. Evaluates and documents the presence or absence of cognitive signs suggesting delirium and need for emergency intervention and includes:
(1) An evaluation of the need for an immediate medical assessment by a physician (preferably a psychiatrist), APRN, PA, or RN;
(2) A general medical history that identifies all medical conditions that an individual has, and includes:
(a) Medical considerations of how these conditions affect the individual's overall current condition and;
(b) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);

(3) A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and
(4) In emergency care, an appropriate physical health assessment; or
(5) In urgent care, a written procedure, approved by the medical director, is implemented to assess the need for referral for a physical health assessment including laboratory screening;

vii. Support and coping skills domain. Documents an individual's:
(1) Current support systems; current coping skills; historical coping skills used during stressful events; and current ideas for coping with the current crisis episode; and
(2) Ability and willingness to cooperate with the individualized crisis treatment plan;

viii. Identification of social, environmental, and cultural factors that may be contributing to the emergency; and

ix. Final outcome. Documents the creation of the crisis and safety plan(s) and the outcome of the current crisis episode.

6. Education and Documentation

a. Education. MCOTs must provide appropriate educational information and crisis support resources that are relevant to stabilizing the crisis episode to individuals or family members, adult care givers, or LARs.

b. Safety plan documentation. MCOT must complete a safety plan with individuals when clinically indicated and provide the individual a copy. MCOTs document the following information self-reported by the individual in crisis:

i. Warning signs - (thoughts, images, mood, situation, behavior) that a crisis may be developing;

ii. Internal coping strategies – what an individual can do independently to redirect focus from problems without contacting another person (relaxation technique, physical activity, etc.);

iii. The names and contact information for people and places that provide distraction from problems;

iv. The names and contact information for people whom the individual can ask for help during a crisis;

v. The names and contact information for professionals or agencies the individual can contact during a crisis; and

vi. Ways of making the environment safe including: limiting access to weapons or other means of harm to the individual or others; and limiting the use, misuse, or abuse of harmful substances, including prescription and non-prescription medications.

c. Individualized crisis treatment plan documentation. An individualized crisis treatment plan must be developed and implemented for everyone. The individualized crisis treatment plan must be based on the symptomology and clinical presentation of the individual and includes, to the extent possible, individual or family members', adult care giver's or LAR's preferences. The individualized crisis treatment plan must

be adjusted whenever necessary to incorporate the individual's response to previous treatment. The individualized crisis treatment plan must recommend the most effective, and least restrictive, available treatment and include:

i. Interventions;
ii. Outcomes;
iii. Plans for follow-up and aftercare; and
iv. Referrals.

7. Coordination of Services

a. MCOT must provide coordination of crisis services in accordance with 26 TAC §301.327 (relating to Access to Mental Health Community Services). Coordination of crisis services must:
   i. Be provided for every individual;
   ii. Consist of identifying and linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care;
   iii. Provide necessary assistance in accessing those services and conducting follow-up and relapse prevention services to determine the individual's status and need for further services; and
   iv. Include contacting and coordinating with the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.
   v. Referral decisions must include consideration of an individual's ability to understand and accept the need for treatment (if such need exists), the ability to comply with the treatment referral, and any treatment wishes listed in an individual's Declaration for Mental Health Treatment.
b. Emergency care services. If a mental health emergency is evident after assessment, the MCOT must provide immediate crisis intervention. MCOT must check availability of clinically appropriate environments to ensure safety and provision of a physician's assessment to determine further treatment for the individual, per 26 TAC §301.327 (relating to Access to Mental Health Community Services).
c. MCOT will provide the receiving facility or service provider all relevant crisis documentation before or at the time of the individual's admission, in accordance with 26 TAC §306.163 (relating to Most Appropriate and Available Treatment Options). The provided crisis information must include the individual's:
   i. identifying information, including address;
   ii. legal status (e.g., regarding guardianship, charges pending, custody) as applicable;
   iii. pertinent medical and medication information, including known disabilities;
   iv. behavioral information, including information regarding COPSD;

v. other pertinent treatment information;
vi. finances, third-party coverage, and other benefits, if known; and
vii. advance directive; and

d. Develop an individualized crisis treatment plan including an intervention, outcome, follow-up plans, aftercare, and referral.
e. Emergency medical services. If a medical emergency is evident, MCOT will arrange for immediate medical care to prevent death or worsening of physical illness or injury. MCOT must provide relevant crisis documentation to the medical provider and coordinate services for the individual based upon the individual's health status and medical provider's recommendations.
f. Transportation. MCOT or an individual's family member, adult care giver, or LAR may transport the individual for crisis stabilization services. If the MCOT member determines that they cannot transport the individual safely, they may arrange for or coordinate transportation with law enforcement.

8. Continuity of Care

a. Upon resolution of the crisis episode, crisis follow up and continuity of care for eligible individuals must include:
   i. Transition to a non-crisis level of care as medically necessary;
   ii. Crisis follow-up and relapse prevention, either by the MCOT or another community services provider, throughout a 90-day period (Level of Care 5) until the individual is stabilized or transitioned to appropriate behavioral health services; and
   iii. Linking children, adolescents, and families with intensive evidenced-based treatments aimed at reducing further risk of out-of-home placement as soon as possible.
b. If the screening indicates that an individual needs routine care services:
   i. A QMHP-CS must perform a uniform assessment within 14 days after the screening, in accordance with 26 TAC §301.327(d)(2) (relating to Routine care services); and
   ii. The uniform assessment must be performed using the assessment tool adopted by HHSC that is used for recommending an approved level of care or other HHSC-approved assessment tool. The current tools are the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths Assessment (CANS).

III. Walk-In Crisis Services

A. Definition

Walk-in crisis services are office-based crisis services providing immediate screening and assessment and brief, intensive interventions focused on resolving a crisis and preventing admission to the least restrictive level of care. These walk-in services may be provided in psychiatric emergency services outpatient clinics, psychiatric urgent care clinics, and in routine care clinics. Information Item V. Section IV. Extended Observation Services provides standards for Psychiatric Emergency Services Centers (PESCs) screening, triage, and assessment services.

B. Goals

- Prompt screening and assessment
- Stabilization in the least restrictive environment
- Crisis resolution
- Linkage to appropriate services

C. Description

Walk-in crisis services are immediately accessible services for adults, children, and adolescents that provide crisis screening, assessment and treatment. Walk-in crisis services are designed to be intensive and time-limited and are provided until the crisis is resolved or the person is referred to another level of care. Walk-in crisis services are offered in LMHA and LBHA service areas based on availability of LMHA or LBHA funding.

For individuals whose crisis screening or assessment indicate that they are presenting with imminent risk of harm to themselves or others in their immediate environment, rapid transfer to a higher level of care is facilitated. If extreme risk of harm is ruled out, brief crisis intervention services are provided on-site.

D. Standards

1. Availability

a. The LMHA or LBHA must provide immediate access to qualified staff to provide crisis screening, assessment and intervention services during hours of operation.
b. Children and adolescent walk-in crisis service hours must be flexible to meet family needs.

2. Physical plant

a. The location of the walk-in crisis services must be clearly marked from the street, and the LMHA or LBHA must include the location in printed and online service literature and social media accounts, as well as in community resource directories.
b. The LMHA's or LBHA's offices must meet all Americans with Disabilities Act Accessibility Guidelines and Texas Accessibility Standards.

c. The LMHA's or LBHA's offices must have at least one designated area where individuals deemed at imminent risk of harm to themselves or others in their immediate environment can be safely maintained and observed until transported to a higher level of care.
d. The LMHA's and LBHA's office spaces must provide an individual with privacy for protection of confidentiality.

3. Staffing

a. A psychiatrist must serve as the medical director for all crisis services and approve all written procedures and protocols.
b. Duties and responsibilities for all staff involved in assessment or treatment must be defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice and in conformance to state standards for licensing and credentialing.
c. All crisis service staff members must receive crisis training that includes but is not limited to:
    i. Identifying signs, symptoms, and crisis response related to substance use and use;
    ii. Identifying signs, symptoms, and crisis response to trauma, abuse and neglect;
    iii. Identifying signs, symptoms, and crisis response to individuals with intellectual disability and development disabilities;
    iv. Identifying specialized assessment and intervention strategies for children, adolescents, and families;
    v. Assessing individuals and providing intervention;
    vi. Conducting suicide screenings and assessments, homicide screenings and assessment, and risk of deterioration screenings and assessments;
    vii. Applying knowledge and effective use of communication strategies such as a range of early intervention, de-escalation, mediation, problem-solving, and other nonphysical interventions according to 25 TAC, Chapter 415, Subchapter F (relating to Interventions in Mental Health Services);
    viii. Completing clinical interviews in behavioral health crisis care for staff such as a physician (preferably a psychiatrist), Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), Physician's Assistant (PA), LPHA, or Qualifies Mental Health Professional – Community Services (QMHP-CS); and
    ix. Using telehealth or telemedicine technology, if applicable. Telemedicine and telehealth competencies must be included for positions in which a staff member's job duties are related to or involve assisting with telemedicine or telehealth services and include adequate and accurate knowledge of:
        (1) operation of the telemedicine or telehealth equipment; and
        (2) how to use the equipment to adequately present the individual.
d. Children's counseling must be provided by LPHAs with additional experience, training, and competency in child and adolescent treatment issues and working with children and families in crisis.

e. All crisis services staff members must be trained physicians (preferably psychiatrists), APRNs, PAs, RNs, LPHAs, QMHP-CSs or trained and competent crisis support staff.
f. All staff providing crisis screening, assessment, and intervention must be physicians (preferably psychiatrists), APRNs, PAs, RNs, LPHAs, or QMHP-CSs
g. A physician (preferably a psychiatrist), or APRN or PA must be available for telephone consultation or face-to-face in person or telemedicine assessment based on the crisis assessment.
h. The LMHA or LBHA must develop and implement written policy and protocol ensuing access to emergency LMHA or LBHA resources when the level of risk to an individual or staff member exceeds the capability of on-site staff.
i. Staff members who are trained in, and prepared to provide, first-responder health care, including Basic Life Support and First Aid, must be on site at all times during business hours when emergency medical services are not available on site.
j. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

4. Crisis Screening, Triage, and Assessment

a. Crisis Screening and Triage. All screening and triage activity must be documented in the health record of an individual receiving services.
   i. Individuals must be screened by a QMHP-CS, a APRN, PA, or RN within 15 minutes of presentation, with procedures to prioritize individuals with imminently dangerous behaviors.
   ii. The LMHA or LBHA must provide a safe and secure location with constant staff observation and monitoring until the individual is triaged.
   iii. Trained staff who are prepared to provide first-responder health care (Basic Life Support,
   First Aid, etc.) must be on site at all times when emergency medical services are not available on site. The LMHA or LBHA must develop and implement a written policy and procedure for crisis screening that addresses:
      (1) Screening for emergency medical conditions;
      (2) The process for accessing emergency medical intervention; and
      (3) For determining when to call 911.
   iv. The LMHA or LBHA must develop and implement a written policy and procedure that describes the process for performing triage. The triage process must include an evaluation of the:
      (1) Risk of harm to self or others;
      (2) Presence or absence of cognitive signs suggesting delirium;
      (3) Need for immediate full crisis assessment;
      (4) Need for emergency intervention;
      (5) Need for a medical screening or medical assessment, including vital signs and a medical history; and

(6) Need for lab work.

v. The LMHA or LBHA must develop and implement a written policy and procedure to determine criteria for deciding which individuals presenting for care are served by the walk-in service provider and which individuals are referred to another health care provider or facility. Individuals considered for referral to a lower level of care must meet the following criteria:
   (1) Low risk of harm to themselves or others;
   (2) Have no more than mild functional impairment; and
   (3) Do not have significant medical, psychiatric, or substance use disorders.
   (4) Referral decisions must include consideration of an individual's ability to understand and accept the need for treatment (if such need exists), the ability to comply with the treatment referral, and any treatment wishes listed in an individual's Declaration for Mental Health Treatment.

b. Assessment. An individual who was not referred to another provider or facility for crisis care after triage must receive a full crisis assessment, including a psychiatric and medical assessment, when ordered by a physician (preferably a psychiatrist). All assessment activity must be documented in the health record of an individual receiving services.
   i. An assessment must be initiated by an LPHA or RN within one hour of referral from the screening process.
   ii. The LMHA or LBHA must develop and implement a written policy and procedure that ensures that an LPHA or RN initiates the full crisis assessment process within 15 minutes of initial presentation to walk-in crisis services for individuals who require immediate assessment due to imminent risk of harm.
   iii. A physician (preferably a psychiatrist), or a APRN or PA must be available to examine and complete a psychiatric assessment for an individual in emergent crisis between three and eight hours from presentation to the services.
   iv. A crisis assessment must be completed face-to-face, in person or through telehealth or telemedicine, in accordance with 26 TAC Subchapter G, §301.321 (b)(2). Clinical interviews must be conducted by a physician (preferably a psychiatrist), APRN, PA, RN, LPHA, or QMHP-CS with training in behavioral health crisis care. A crisis assessment must include historical and current information within the following:
      (1) Mental health domain. Documents an individual's: symptomology; functionality; historical and current diagnoses and treatment for mental health, serious emotional disturbance, or intellectual disability and developmental disorder diagnoses. The assessment must include:
         (a) A review of records of the individual's past treatment (when available);
         (b) History from collateral sources. The team is proactive in gathering input or corroboration of events from family members, adult care givers, or LARs whenever possible. Every effort must be made to

engage family, adult care givers, or LAR support around the individual in crisis while maintaining confidentiality;

(c) Contact with the individual's current healthcare providers whenever possible; and

(d) If available, a history of the individual's previous mental health, substance use, intellectual disability or developmental disability treatment that includes:

(i) A record of past psychiatric medication, dosages, response to medications, side effects and adherence;

(ii) An up-to-date record of all medications currently prescribed and the name of the prescribing professional;

(iii) An individual's collateral resources or current healthcare providers. Identification of social, environmental, and cultural factors that may be contributing to the crisis; and

(iv) An attempt to determine if the individual has an active Declaration for Mental Health Treatment when interviewing the individual and the and the individual's collateral resources or current healthcare providers.

(2) Suicide domain. Documents an individual's: current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;

(3) Violence domain. Documents an individual's: current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;

(4) Trauma, abuse, and neglect domain. Documents an individual's: current and past trauma or abuse and neglect; where the trauma or abuse and neglect was experienced; and how long the trauma or abuse and neglect occurred;

(5) Substance use domain. Documents an individual's: current use and how their use affects their thoughts and behaviors regarding suicide and violence; the last time of use; the history of substance use and recovery status; history of use, abuse, or overdose on alcohol, drugs, medications, or other substances;

(6) Physical and cognitive health domain. Evaluates and documents the presence or absence of cognitive signs suggesting delirium and need for emergency intervention and includes:

(a) An evaluation of the need for an immediate medical assessment by a physician (preferably a psychiatrist), APRN, PA, or RN;

(b) A general medical history that identifies all medical conditions that an individual has, and includes:

(i) Medical considerations of how these conditions affect the individual's overall current condition and;

(ii) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);

(c) A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and

(d) An LMHA or LBHA must ensure the creation and implementation of a written policy that describes the process used in urgent care situations to:

(i) assess the need for referring an individual for a physical health assessment, including laboratory screening; and

(ii) Coordinate referral to those assessment and laboratory services.

(e) An LMHA or LBHA must ensure the creation and implementation of a written policy that describes the process used in an emergent care situation to refer an individual to an appropriate facility, such as an emergency department, Extended Observation Unit with access to medical services, or a Psychiatric Emergency Services Center.

(7) Support and coping skills domain. Documents an individual's:

(a) Current support systems; current coping skills; historical coping skills used during stressful events; and current ideas for coping with the current crisis episode; and

(b) Ability and willingness to cooperate with the individualized crisis treatment plan; and

(8) Identification of social, environmental, and cultural factors that may be contributing to the emergency; and

(9) Final outcome. Documents the creation of the crisis and safety plan(s) and the outcome of the current crisis episode.

5. Intervention

a. A written policy and procedure must be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the walk-in crisis services and is approved by the medical director. The policies and procedures must be reviewed and updated as needed.

b. A written policy and procedure must be developed and implemented for providing immediate crisis intervention and safe transportation of an individual to an appropriate facility if screening or assessment indicates the need for a higher level of care to ensure safety or further treatment. The individual must be monitored continuously until transferred.

c. A crisis treatment plan that provides the most effective and least restrictive treatment available must be developed and implemented for each individual. The plan must be based on the provisional psychiatric diagnosis and incorporates, to the extent possible, individual and family preferences. The plan must address intervention, outcomes, plans for follow-up and aftercare, and referrals.

d. Whenever necessary, the crisis treatment plan must be adjusted to incorporate the individual's response to previous treatment.
e. Individuals and families must receive appropriate educational information that is relevant to their condition, including information about the most effective treatment for the individual's behavioral health disorder.
f. The medical director must define appropriate reassessment intervals for emergent, urgent, and routine care.
g. Children's counseling must be provided by LPHAs with additional experience, training, and competency in child and adolescent treatment issues and working with children and families in crisis.
h. Services provided must link families with intensive evidence-based treatments aimed at reducing risk of out of home placement.

6. Coordination and Continuity of Care

a. Coordination of crisis services must be provided for every individual. Coordination of crisis services consists of:
    i. Linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care;
    ii. Conducting follow-up and relapse prevention services to determine the individual's status and need for further service; and
    iii. Contacting and coordinating with the individual's existing service providers in a timely manner and in conformance with applicable confidentiality requirements.
b. Upon resolution of the crisis, eligible individuals must be transitioned to an appropriate level of care (LOC) as determined by medically necessity.
c. The individual must receive crisis follow-up and relapse prevention either by the MCOT or from another community service provider throughout a 90-day period (LOC 5: Transitional Services) until they are stabilized or transitioned to appropriate behavioral health services.

IV. Extended Observation Unit

A. Definition

Extended Observation Units (EOUs) operated by a LMHA or LBHA provide adult individuals, presenting on voluntary or involuntary status, with access to emergency psychiatric care 24 hours a day, every day of the year. EOU facilities may also provide services to children and adolescents. EOU services are provided in a safe and secure environment and staffed by medical personnel, mental health professionals, and trained crisis support staff. All EOU services must be delivered in accordance with Texas Health and Safety Code (THSC) Chapter 573 (relating to Emergency Detention); Title 26 Texas Administrative Code (TAC) Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and 26 TAC Chapter 306, Subchapter D (relating to Mental Health Services—Admission, Continuity, and Discharge).

EOUs must have the ability to serve individual with psychiatric symptoms ranging from moderate to severe, depending on the EOU's level of observation services, and coordinate an individual's transfer to a higher level of care after 48 hours when clinically indicated and ordered by a physician, preferably a psychiatrist.

B. Goals for Extended Observation

- Provide prompt and comprehensive assessment for individuals during a behavioral health crisis, in accordance with 26 TAC §301.327(d)(C) (relating to Urgent care services)
- Provide immediate crisis assessment, psychiatric evaluation, and treatment for individuals experiencing a behavioral health emergency, in accordance with 26 TAC §301.327(d)(B) (relating to Emergency care services)
- Prompt crisis stabilization in a secure environment
- Provide crisis resolution and linkage to appropriate services
- Provide transition to clinically appropriate levels of care when a crisis cannot be stabilized in a less restrictive setting
- Reduce inpatient and law enforcement interventions

C. Description

Extended Observation services are provided under supervision of a psychiatrist. The duration of an individual's extended observation services must not exceed 48 hours. If an individual is unable to gain behavioral health stabilization after 48 hours, the treating physician must determine the next appropriate level of care for the individual. Continuity of care services are provided to ensure that the individual is transferred to continuing treatment and linked with recommended support services.

D. Standards

An LMHA or LBHA may provide extended observation services in a free-standing EOU or in an EOU in a Psychiatric Emergency Service Center (PESC). The availability of an EOU in

either location is dependent upon community needs and available funding. Standards located in D. Standards 3-10, E. Crisis Screening and Triage, F. Crisis Assessment, G. Treatment, H. Discharge Planning, and I. Medication Standards are applicable to all EOUs.

1. Free Standing EOU Facility

A free-standing EOU must maintain:

a. A location near a licensed hospital or a Crisis Stabilization Unit (CSU) licensed in accordance with 26 TAC Chapter 510 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units), to provide individuals with access to urgent or emergency medical stabilization services and emergency psychiatric stabilization services; and
b. Adherence to general facility standards described in subsections J-O of this section.

2. PESC Facility

A PESC includes extended observation beds and services in a secure treatment environment that is co-located in a licensed hospital or in a CSU licensed in accordance with 26 TAC Chapter 510 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units). A PESC provides walk-in access to immediate behavioral health emergency screening and assessment, extended observation services, and a continuum of crisis and behavioral emergency stabilizing treatment for individuals whose behavioral symptoms cannot be stabilized within 48 hours.

a. A PESC must provide a combination of services that includes, at minimum:
    i. Extended Observation services, as described in A. Description of this section, in a designated area of the PESC; and
    ii. Inpatient services in an environment designed to provide safety and security during acute behavioral health crisis; or
    iii. CSU services in a secure and protected treatment environment that complies with CSU licensure requirements.
b. The LMHA or LBHA providing PESC services must have a written agreement with the hospital or CSU with which the PESC is co-located and must ensure that the PESC facility:
    i. Is accessible and meets all ADA Accessibility Guidelines, Texas Accessibility Standards, and applicable sections of the TAC;
    ii. Has provisions for ensuring the personal safety of both individuals receiving services and PESC staff members;
    iii. Has at least one designated area where individuals in acute crisis can be safely maintained and monitored until transported to a hospital or CSU;
    iv. Has spaces that provide privacy for the protection of confidentiality of an individual providing information and for a staff member receiving information; and

v. maintains separate child, adolescent, and adult treatment and observation areas in facilities where services are provided for children and adolescents.

3. Eligibility Criteria

An EOU in any location must adhere to the following eligibility requirements:

a. Develop and implement a written process and procedure that outlines eligibility criteria for admission into the EOU;
b. QMHP-CS must conduct a crisis screening to determine if an individual meets eligibility criteria that may result in acceptance into the EOU;
c. Admission to the EOU must be based on medical necessity as determined by the physician, preferably a psychiatrist; and
d. The facility must not admit an individual whose acuity level cannot be effectively managed in the EOU as determined by a physician, preferably a psychiatrist. An individual that requires a more restrictive or less restrictive level of care must be referred the more appropriate treatment setting.

4. Capacity to Consent.

An individual with capacity to consent to EOU treatment, services, and medications, as determined by a physician, preferably a psychiatrist, must give written consent to receive mental health services, including medication and laboratory services. If an individual is in a psychiatric emergency regardless of consent, the individual may be administered emergency medication in accordance with 25 TAC Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication--Mental Health Services).

5. Admission Status and Egress.

Regardless of voluntary or involuntary admission status at time of presentation, everyone must receive information about their rights and a Rights Handbook in accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services).

a. Individuals presenting to an EOU on voluntary status may:
   i. Be admitted into services by a physician, preferably a psychiatrist;
   ii. Have access to, with or without supervision, approved areas of the EOU located away from the individual's bed or unit; and
   iii. Receive services in the least restrictive environment available, consistent with the protection of the individual and the protection of the community.
b. Individuals presenting to an EOU on emergency detention status may be safely maintained and observed in a locked unit, in accordance with THSC Chapter 573.
c. Individual being detained under emergency detention must be released if:

i. A physician (i.e., preferably a psychiatrist) determines that the individual no longer meets the criteria for emergency detention; or
ii. When the emergency detention 48-hour maximum hold has expired; and
iii. The individual shall be discharged to the community, discharged and readmitted as a voluntary admission, or transferred to an appropriate level of care.

d. In accordance with THSC 573.021, if the 48-hour period ends on a Saturday, Sunday, legal holiday, or before 4 p.m. on the first succeeding business day, the person may be detained until 4 p.m. on the first succeeding business day. If the 48-hour period ends at a different time, the person may be detained only until 4 p.m. on the day the 48-hour period ends. If extremely hazardous weather conditions exist or a disaster occurs, the presiding judge or magistrate may, by written order made each day, extend by an additional 24 hours the period during which the person may be detained. The written order must declare that an emergency exists because of the weather or the occurrence of a disaster.
e. An individual on voluntary status who makes a request to discharge, in any format, shall be honored as a request to leave. The individual's request for discharge shall be processed as soon as possible. The individual shall be discharged with at minimum the individual's belongings and medications. Staff shall immediately notify the LPHA and physician (preferably a psychiatrist) of the individual's request.

6. Length of Stay.

Extended observation services can take place for up to 23 hours or up to 48 hours, depending on the physical setting of the facility as described in subsection 7. Observation Area of this section. An individual who cannot be stabilized within that timeframe must be referred and linked to the appropriate level of care such as an inpatient hospital unit or CSU. The LMHA or LBHA must develop and implement written policies and procedures for serving individuals admitted on emergency detention after the 48 hours has expired.

7. Observation Area.

The LMHA or LBHA providing, or subcontracting, extended observation services must ensure the observation area of any EOU physical plant provides:

a. A designated area where an individual experiencing acute symptoms can be observed and safely maintained until the crisis is resolved or the individual is transported to another level of care;
b. A separate bed for each individual in a facility providing 48-hour observation;
c. Staff monitoring at all times for:
    i. The area with chairs or beds in a shared room or bedrooms, in a 23-hour observation facility;
    ii. The beds in any shared bedroom; and

iii. Private bedroom areas, with direct observation of the individual in the bedroom conducted no more than 15 minutes apart;

d. One-to-one continuous observation of an individual when ordered by the treating physician;
e. Privacy for the protection of confidentiality, when an individual providing, or a staff member is obtaining any information protected under the Health Insurance Portability and Accountability Act (HIPAA) rules or other applicable federal or state laws concerning confidentiality;
f. Separate observation areas for children, adolescents, and adults; and
g. A secure environment in which exterior doors may be locked and monitored for the safety and protection of individuals and staff.

8. Staffing

a. A psychiatrist must serve as the medical director for all crisis services and approve all crisis services policies and procedures, in accordance with 26 TAC §301.321(b) (relating to Management of key processes and functions).
b. Staffing plans must:
   i. Adhere to the following standards for EOUs and not follow the staffing plans of a facility that provides a lower level of care;
   ii. Adjust nursing support staff numbers as clinically indicated to address the number and acuity of individuals served;
   iii. Provide licensed and credentialed staff to ensure the availability of:
      (1) A physician, preferably a psychiatrist, or a APRN or PA, to be on call 24 hours a day, every day of the year, to evaluate an individual face-to-face or through telemedicine services, as needed;
      (2) At least one LPHA must be available on site every day of the year from 8:00 a.m. to 8:00 p.m., and through telehealth after hours, as needed;
      (3) At least one RN on site 24 hours a day, every day of the year;
      (4) At least one QMHP-CS on site between the hours of 8 a.m. to 7 p.m. and assigned to identified individuals on each shift; and
      (5) At least three trained and competent crisis support staff on site 24 hours a day, every day of the year.
   iv. Provide a sufficient number of available physicians, preferably psychiatrists, or APRNs, PAs, and RNs to provide initial assessment of individuals in services through:
      (1) An RN nursing assessment initiated within 15 minutes of an individual's presentation to an EOU;
      (2) An LPHA assessment initiated within one hour of an individual's presentation at the EOU;
      (3) A physician preliminary examination, conducted through in-person or telemedicine services, within eight hours of an individual's presentation at the EOU.
   v. Provide a sufficient number of available LVNs, LPHAs, QMHP-CSs, and trained and competent crisis support staff to allow for the provision of:

(1) Reassessment of the progress of each individual in service at a minimum of every:
(a) 15 minutes, by trained and competent crisis support staff;
(b) Two hours by licensed nurses;
(c) Four hours by QMHP-CSs; and
(d) 12 hours by physicians, preferably psychiatrists, or
(e) APRNs or PAs;
(2) Active group or individual therapeutic interventions required by the individual's treatment plan and consistent with the individual's clinical state; and
(3) Patient and staff personal safety, including one to one observation as needed.

c. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

9. Duties and Responsibilities.

An LMHA or LBHA must define in writing duties and responsibilities for all staff involved in the assessment or treatment of individuals receiving services. Assigned duties and responsibilities must be appropriate to staff training, experience, and displayed competencies and remain in conformance with the staff's scope of practice, or state licensing and credentialing standards.

a. A psychiatrist must serve as the medical director for all crisis services and must approve all policies and procedures used in crisis services.
b. All EOU staff members must receive crisis training and meet required competencies in accordance with 26 TAC §301.3313(a)(3)(A) (relating to Required Competencies) and with 26 TAC §301.3313(a)(3)(B) (relating to Critical Competencies).
c. All EOU staff members involved in the assessment or treatment of individuals in services must meet specialty competencies in accordance with 26 TAC §301.331(a)(3)(C) (relating to Specialty Competencies).
d. All EOU staff members providing crisis services and interventions must meet specialty competencies in accordance with 26 TAC §301.331(b) (relating to Competency of Crisis Services Providers).
e. An LMHA or LBHA must develop and implement written policies and procedures for RNs to make assignments to LVNs, or delegate to crisis support staff, nursing acts for the care of stable individuals with common, well-defined health problems with predictable outcomes, in accordance with 26 TAC §301.355(b) (relating to Medication Service Delivery). The policies must address types of nursing acts that may be delegated, the method to ensure the staff is trained and qualified to perform a delegated nursing act, and the frequency of nursing supervision.

f. Clinical supervision must be provided and documented for all staff members, and all licensed staff members must be supervised in accordance with their practice and applicable rules, in accordance with 26 TAC §301.363 (relating to Supervision).

10. Service Availability.

The EOU must adhere to the following service availability requirements.

a. Available 24 hours a day, every day of the year, throughout the participating service areas.
b. Delivered in accordance with utilization management guidelines and authorization of services and timeframes, in accordance with 301.355(c)(1) (relating to Utilization Management). A diagnosis is not required when services are delivered in a crisis level of care such as the services provided in an EOU. Crisis services must be authorized within two business days of presentation.

E. Crisis Screening and Triage

1. All screening and triage activity must be documented in the health record of an individual receiving services.
2. Individuals must be screened by a physician (preferably a psychiatrist), an APRN, PA, or RN within 15 minutes of presentation, with procedures to prioritize individuals with imminently dangerous behaviors.
   a. Until the individual is triaged, they must wait in a safe and secure location with constant staff observation and monitoring.
   b. Trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, etc.) must be on site at all times when emergency medical services are not available on site. The LMHA or LBHA must develop and implement a written policy and procedure for crisis screening that addresses:
      i. Screening for emergency medical conditions;
      ii. The process for accessing emergency medical intervention; and
      iii. For determining when to call 911 for assistance.
   c. The LMHA or LBHA must develop and implement a written policy and procedure that describes the process for performing triage. The triage process must include:
      i. An evaluation of risk of harm to self or others;
      ii. The presence or absence of cognitive signs suggesting delirium;
      iii. The need for immediate full crisis assessment;
      iv. The need for emergency intervention;
      v. The need for a medical screening or medical assessment, including vital signs and a medical history; and
      vi. Lab work.
   d. The LMHA or LBHA must develop and implement a written policy and

procedure to determine criteria for deciding which individuals presenting for care are referred to the provider or to another health care facility. Individuals considered for referral to a lower level of care must meet the following criteria:

i. Low risk of harm to themselves or others;
ii. Have no more than mild functional impairment; and
iii. Do not have significant medical, psychiatric, or substance use disorders. Referral decisions must consider the individual's ability to understand and accept the need for treatment (if such need exists) and to comply with the referral.

F. Crisis Assessment

After triage, an individual who is not referred elsewhere for care must receive a full crisis assessment, including a psychiatric and medical assessment, when ordered by a physician (preferably a psychiatrist). All assessment activity must be documented in the health record of an individual receiving services.

1. An LMHA or LBHA must develop and implement written policies and procedures for:
    a. Crisis assessments. QMHP-CS crisis assessments must be conducted using assessment tools adopted by the Health and Human Services Commission (HHSC) for recommending and authorizing a Level of Care (LOC);
    b. LPHA diagnostic assessments. LPHA diagnostic assessments must be initiated within one hour of an individual's presentation at the EOU. The LMHA or LBHA must develop and implement a written policy and procedure that allows individuals requiring immediate LPHA assessment to be assessed by an LPHA within 15 minutes.
    c. Physician assessment. An individual who receives an LPHA diagnostic assessment must next receive a preliminary examination, comprised of medical and psychiatric assessment, from a physician, preferably a psychiatrist, within eight hours of presentation at the EOU. The physician may conduct a face-to-face examination of an individual through an in-person or telemedicine interview, as needed.
2. Crisis assessments must be conducted using assessment tools adopted by HHSC for recommending and authorizing a LOC.
3. All individuals under the age of 18 years old must receive a developmental assessment by an LPHA with appropriate training in the assessment and treatment of children and adolescents in a crisis setting.
4. A crisis assessment must be completed face-to-face, in person or through telehealth or telemedicine, in accordance with 26 TAC Subchapter G, §301.321 (b)(2). Clinical interviews must be conducted by a physician (preferably a psychiatrist), APRN, PA, RN, LPHA, or QMHP-CS with training in behavioral health crisis care.
5. A crisis assessment must include historical and current information within the following domains:

a. Mental health domain. Documents an individual's: symptomology; functionality; historical and current diagnoses and treatment for mental health, serious emotional disturbance, or intellectual disability and developmental disorder diagnoses. The assessment must include:
   i. A review of records of the individual's past treatment when available;
   ii. History from collateral sources. The team is proactive in gathering input or corroboration of events from family members, adult care givers, or LARs whenever possible. Every effort must be made to engage family, adult care givers, or LAR support around the individual in crisis while maintaining confidentiality;
   iii. Contact with the individual's current healthcare providers whenever possible; and
   iv. If available, a history of the individual's previous mental health, substance use, intellectual disability or developmental disability treatment that includes:
      (1) A record of past psychiatric medication, dosages, response to medications, side effects and adherence;
      (2) An up-to-date record of all medications currently prescribed and the name of the prescribing professional;
      (3) Identification of social, environmental, and cultural factors that may be contributing to the crisis; and
      (4) An attempt to determine if an individual has an active Declaration for Mental Health Treatment when interviewing the individual and the and the individual's collateral resources or current healthcare providers.
b. Suicide domain. Documents an individual's: current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;
c. Violence domain. Documents an individual's: current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;
d. Trauma, abuse, and neglect domain. Documents an individual's: current and past trauma or abuse and neglect; where the trauma or abuse and neglect was experienced; and how long the trauma or abuse and neglect occurred;
e. Substance use domain. Documents an individual's: current use and how their use affects their thoughts and behaviors regarding suicide and violence; the last time of use; the history of substance use and recovery status; history of use, abuse, or overdose on alcohol, drugs, medications, or other substances;
f. Physical and cognitive health domain. Evaluates and documents the presence or absence of cognitive signs suggesting delirium and need for emergency intervention and includes:
   i. An evaluation of the need for an immediate medical assessment by a physician (preferably a psychiatrist), APRN, PA, or RN;
   ii. A general medical history that identifies all medical conditions that an individual has, and includes:
      (1) Medical considerations of how these conditions affect the individual's overall current condition and;

(2) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);

iii. A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and

g. Support and coping skills domain. Documents an individual's:

i. Current support systems; current coping skills; historical coping skills used during stressful events; and current ideas for coping with the current crisis episode; and

ii. Ability and willingness to cooperate with the individualized crisis treatment plan; and

h. Identification of social, environmental, and cultural factors that may be contributing to the emergency; and

i. Final outcome. Documents the creation of the crisis and safety plan(s) and the outcome of the current crisis episode.

6. Physical health assessment. An individual must receive a physical health assessment within four hours of presentation to the EOU, unless it has been clinically determined the individual requires immediate assessment within 15 minutes of the clinical determination. The LMHA or LBHA must develop and implement written policies and procedures that ensures that those who require a physical health assessment immediately can be seen and assessed within five minutes of initial presentation. The initial assessment for physical health must be performed as ordered by a physician (preferably a psychiatrist), an APRN, or a PA. The physical health assessment must include:

a. A cognitive examination that screens for significant cognitive or neuron-psychiatric impairment and documents of the presence or absence of cognitive signs suggesting delirium and the need for emergency intervention;

b. A screening neurological examination that is adequate to rule out significant acute pathology;

c. A general medical history that identifies all medical conditions of an individual, and includes:

i. Medical considerations of how these conditions affect the individual's overall current condition;

ii. A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment, including history of traumatic brain injury;

iii. A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition; and

iv. A review of need for immediate full assessment, need for emergency intervention, and a medical screening assessment, including vital signs and a medical history, whenever possible.

d. Immediate access to on-site phlebotomy, urine collection, and rapid turnaround laboratory tests and evaluations must be provided, as clinically indicated. A

written policy and procedure must identify labs that will be made available and may include:

i. A complete blood count with differential;
ii. A comprehensive metabolic panel;
iii. A thyroid screening panel;
iv. A toxicology evaluation;
v. A pregnancy test for females of child bearing age;
vi. A screening test for tertiary syphilis;
vii. Psychiatric medication levels;

e. Other tests or evaluations, as appropriate, based on the patterns of illness in the individuals served;
f. Screening for intoxication and, when indicated, screening for symptoms and complications of substance withdrawal must be provided; and
g. A neurological examination that is adequate to rule out significant acute pathology;
h. On-site capability for such routine assessments as pulse oximetry, glucometry (or stat blood glucose testing), point of care urine toxicology screening (results available within four hours), and a targeted physical examination.

G. Treatment

All treatment activities must be documented in the individual's clinical record. The LMHA or LBHA must develop and implement written policies and procedures to ensure the provision of:

1. Immediate intervention to stabilize a behavioral health emergency. These procedures must describe the most effective and least restrictive approaches to common psychiatric emergencies seen in EOUs with walk-in crisis services, including behavioral health intervention that must always be available to prevent harm to individuals receiving EOU services and others in the facility. These procedures must reviewed, updated and approved by the medical director every three years, with revisions submitted in accordance with Information Item S.
2. Nursing care plans. These plans must be developed by an RN and implemented for every individual receiving services. A response to treatment must be assessed at least every two hours by an RN trained in the assessment of individuals with acute behavioral health conditions or by a physician, preferably a psychiatrist, APRN or PA.
3. Education and Crisis Treatment and Recovery Plan

    a. Education. Individuals and, if applicable, the individual's family members, LAR, or identified supports must receive appropriate educational information that is relevant to the individual's condition, including information about the most effective treatment for the individual's behavioral health disorder. An LPHA must be responsible for providing the individual with active treatment including:

    i. psycho-education;
    ii. crisis counseling;
    iii. substance use counseling, as indicated;

iv. safety planning; and
v. discharge planning that addresses potential obstacles to a successful return to the community environment.

b. Crisis treatment plan. An individualized crisis treatment plan must be developed and implemented for everyone in services.
i. The plan must be based on the provisional psychiatric diagnosis and incorporates, to the extent possible, the individual's treatment preferences as reported or as indicated an individual's Declaration for Mental Health, and any preferences reported by the individual's family, LAR, or identified support, as applicable.
ii. Crisis treatment planning must place emphasis on providing crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.
iii. The crisis treatment plan must address:
(1) Intervention;
(2) Outcomes;
(3) Plans for follow-up and aftercare; and
(4) Referrals
(5) Safety planning for individuals found at risk of harm to self or others.

c. Plan Implementation. An individualized crisis treatment plan must provide the most effective and least restrictive available treatment and must be adjusted as necessary to incorporate the individual's response to previous treatment.
iv. Counseling on restriction to lethal means and safety planning must be incorporated into the crisis treatment plan when than individual is indicated to be at risk of harm to self during the crisis assessment.
v. The crisis treatment plan must be adjusted as necessary to incorporate the individual's response to previous treatment.

d. Follow up. The individualized crisis treatment plan must address intervention, outcomes, plans for follow-up and aftercare, and referrals.

H. Coordination and Continuity of Care

The LMHA or LBHA must develop and implement written policy and procedures to ensure continuity of care and coordination services to develop successful linkage with the referral facility or provider. All continuity of care and coordination activities must be documented in the clinical record. This service includes contacting, and coordinating with, the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.

a. A written procedure must be developed and implemented for ensuring continuity of care and successful linkage with the referral provider.
b. Continuity of care must:
i. Be provided for every individual;

ii. Consist of identifying and linking the individual with all available services including the substance abuse services necessary to stabilize the crisis and ensure transition to routine care;
iii. Provide necessary assistance in accessing those services and conducting follow-up to determine the individual's status and need for further service; and
iv. Include contacting and coordinating with the individual's existing service providers, when feasible, and in conformance with applicable confidentiality requirements.

c. Coordination of services must include the following requirements:
i. A discharge plan must be initiated for every individual upon admission;
ii. If inpatient treatment is not indicated, the discharge plan must include:
(1) Appropriate education relevant to the individual's condition;
(2) Information about the most effective treatment for the individual's psychiatric condition;
(3) Information about follow-up care;
(4) A list of medications to continue upon discharge, if there are medication changes; and
(5) Appropriate linkages to post discharge providers.

d. If a physical health issue requires hospitalization, the individual must be transferred to the appropriate community hospital to address the physical health issue.

I. Medication Standards

Certain conditions regarding how medications are obtained or provided may require that the facility obtain licensure in accordance with the Texas Board of Pharmacy rules described in 22 TAC, Part 15, Chapter 291 (relating to Pharmacists).

1. Medication storage.

All facilities that provide or store individual's medication during the length of stay must implement written procedures for medication storage, administration, documentation, controlled substances, inventory, and disposal and must adhere to medication standards in the 26 TAC Chapter 301, Subchapter G §301.355, (relating to Medication Services).

a. An LMHA must ensure that an individual:
i. must not retain their personal medications while in the facility; but
ii. must receive that personal medication upon discharge from the facility.

b. Staff must be able to provide a copy of the most recent stock inspection.

c. There must be evidence in the clinical records that individuals are educated about their medications including whenever medications are prescribed or changed.

d. Medications that are kept on-site must be kept locked at all times.

2. Climate controlled medications.

Medications that require special climatic conditions such as refrigeration, darkness, or be tightly sealed must be stored properly.

3. Controlled substances.

a. Controlled substances must be approved by a physician employed by or who contracts with the facility or LMHA or LBHA that operates the EOU.
b. Controlled substances must be stored under double locks.

4. Labeling medications.

a. The facility must ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.
b. Medication labels must not be handwritten or changed.

5. Facility management.

a. Facility management must ensure that only licensed staff have access to medications that are administered to individuals.
b. Facility management must maintain a current list in the medication room of all staff who are licensed to prescribe medications that are dispensed from the medication room.
c. Facility management must maintain a current list of all staff licensed to administer medications in the medication room.
d. The facility must ensure that there is a list in, or near, or within the medication room stating the names of all staff who are authorized access to the medication room.
e. The facility must ensure that staff never transfer medications from one container to another. However, an individual may independently transfer his or her own medications from a bottle to a daily medication reminder.
f. The facility must maintain an emergency medication kit which must:
    i. Be monitored using a perpetual method inventory and make use of breakaway seals; and
    ii. Contain medications and other equipment as specified by the facility medical director. This generally includes, but is not limited to, short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications.
g. There must be a medication guide such as a Physician's Desk Reference (PDR) or similar publication published within the last two years, is available to staff in either electronic or hard copy format.

J. Physical Plant

1. The physical plant must provide a clean and safe environment and have written policies and procedures for monitoring environmental safety in accordance with 26 TAC Subchapter G, §301.312 (relating to Environment of Care and Safety).
2. Any newly constructed or renovated or remodeled unlicensed crisis facility

must receive a pre-operational on-site review by HHSC Quality Management (QM) before opening to the public to provide services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.

3. The facility must report any changes in programming, construction or facility to the HHSC Contracts Manager.

K. Facility Environment

Facility environment requirements are developed in accordance with the American with Disabilities Act (ADA) checklist for existing facilities (http://www.adachecklist.org/).

1. Water/Waste/Trash/Sewage.

The water supply must be of safe, sanitary quality, suitable for use, adequate in quantity and pressure, and must be obtained from an approved water supply system.

a. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
b. Waste, trash and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
c. Hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
d. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.

2. Windows.

Operable windows must be insect screened.

3. Pest control.

An ongoing pest control program must be provided by staff or a licensed pest control company. The least toxic and least flammable effective chemicals must be used.

4. Storage.

a. Storage areas and cellars must be kept in an organized manner.
b. Storage must not be permitted in the attic spaces.

5. Floors, walls, and ceilings.

a. Floors must be clean and maintained in good condition.

b. Walls and ceilings must be structurally maintained, repaired and repainted or cleaned as needed.

6. Bathroom and laundry.

a. At least one water closet and lavatory per every six individuals, and one tub or shower for every ten individuals must be provided in each EOU.
b. Privacy partitions and or curtains must be provided for water closets and bathing units in rooms for multi-individual use.
c. Tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
d. Towels, soap and toilet tissue must be available at all times for individual's use.
e. If laundry is processed off the site, the following must be provided on the premises: a soiled linen holding room; a clean linen receiving, holding, inspecting, sorting or folding and storage room.
f. A laundry for individual's use, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.

7. Building repair/maintenance/and cleaning.

a. The facility must be kept free of accumulations of dirt, rubbish, dust and hazards.
b. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
c. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in areas where individuals receive services.

8. Room space.

a. The room space provided must be at least 80 usable square feet per individual in single-occupancy rooms; or 60 usable square feet per individual in multiple-occupancy rooms.
b. Furnishings provided by the EOU must be maintained in good repair.

L. General Facility

1. Storage.

The facility must provide sufficient, appropriate, and separate storage spaces or areas for the following:

a. Administration and clinical records;
b. Office supplies;
c. Medications and medical supplies that must be locked;
d. Poisons and other hazardous materials must be
    i. Stored in a locked area; and

ii. Stored separate from all food and medications;

e. Food preparation (if the facility prepares food); and
f. Equipment supplied by the facility for individuals' needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment.

2. Smoking.

Staff members must not provide or facilitate individual access to tobacco, vaping products, or electronic cigarette equipment. When a facility permits smoking, the facility must:

a. Establish smoking regulations;
b. Ensure that individuals have designated outdoor smoking areas of safe design; and
c. Ensure that smoking areas contain ashtrays of noncombustible material.

3. Prohibitions.

The facility must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.

4. Telephone access.

The facility must provide at least one telephone in the facility available for use by both staff and individuals.

5. Main area displays.

The following must be prominently displayed in areas frequented by individuals:

a. Contact information for the Rights Protection Officer;
b. Contact information with instructions on how to make an abuse/neglect/exploitation report and the toll-free number for reporting abuse and neglect; and
c. A notice stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the staff responsible for ADA compliance.

6. Postings.

Postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area. The facility must post:

a. A list of names of all staff members permitted access to the medication room located in, near, or within the medication room; and
b. 911 as the emergency contact located at, or within view, of the telephone.

7. Accessibility (ADA Compliance).

At least 10 percent of individuals' bedrooms and toilets, and all public use and common use areas must be designed and constructed to be accessible. The facility must also comply with standards in the most recent version of:

a. Title 28, Code of Federal Regulations, Part 36. (http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title28/28cfr36_main_02.tpl)
b. Americans With Disabilities Acts Accessibility Guidelines (ADAAG); and
c. Texas Accessibility Standards (TAS) and all applicable sections of TAC.

M. Life Safety

1. Life Safety Code.

The facility must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code (IFC). Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.

2. Local fire code.

All facilities must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code as defined by the local fire authority.

3. Code compliance.

Facilities must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the codes referenced in subsections (1) and (2) of this section.

4. Fire drills.

The facility must conduct fire drills and calculate evacuation scores in accordance with the fire code under which the facility is inspected.

a. The administration must have in effect and available to all supervisory staff written copies of a plan for the protection of all individuals in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary.
b. The written plan must:
    i. Identify special staff actions including fire protection procedures needed to ensure the safety of any individual;
    ii. Indicate that all staff must be periodically instructed and informed of their duties and responsibilities under the plan;
    iii. Be amended or revised as needed; and
    iv. Require documentation that reflects the current evacuation capabilities of the individuals.
c. A copy of the plan must be readily available at all times within the facility.

5. Disaster Planning

a. The LMHA or LBHA must develop, implement and make available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, in accordance with 26 TAC Subchapter G, §301.312 (relating to Environment of Care and Safety).
b. The written disaster plan must address, at a minimum, eight core functions:
    i. Direction and control;
    ii. Warning;
    iii. Communication;
    iv. Sheltering arrangements;
    v. Evacuation;
    vi. Transportation;
    vii. Health and medical needs; and
    viii. Resource management.
c. The written disaster plan must include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the facility or during facility evacuation.

6. Recorded inspections.

Facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual, quarterly or other periodic inspections must be signed and dated. The following initial and annual inspections and maintenance are required and must be kept on file:

a. Local fire safety inspection as described in subsection (6)(a) of this section;
b. Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
c. Annual kitchen inspection by the local health authority;
d. Gas pipe pressure test one every three years by the local gas company or a licensed plumber, as required by facility type or licensure;
e. Monthly inspection and annual maintenance of fire extinguishers by personnel licensed or certified to perform the inspection; and
f. Inspection of liquefied petroleum gas systems by an inspector certified by the Texas Railroad Commission, when applicable.

7. Fire safety inspections.

Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal.

a. The facility is responsible for:
    i. Arranging these inspections and for ensuring that these inspections are carried out in a timely manner;

ii. Ensuring the initial and ongoing reports are signed by the certified inspector performing inspection; and
iii. Keeping the reports on file and be readily available for review by the state.

b. All fires causing damage to the facility or to equipment must be reported to the Department's Contract Manager with 72 hours.
c. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Notification must be by telephone if during normal business hours and by e-mail during other times with a follow-up telephone call to the Contract Manager on the first business day following the event.

8. Correction plan.

If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, staff must take immediate corrective action to bring the EOU into compliance with the applicable code. The facility must:

a. Record on file the date for a return inspection by the Certified Fire Inspector to review the corrective actions;
b. After that date, record on file documentation by the Certified Fire Inspector that all deficiencies have been corrected and that the facility is in full compliance with all applicable codes; and
c. During the period of corrective action, take any actions necessary to ensure the health and safety of individuals residing in the facility during the time the repairs or corrections are being completed.

9. New facilities.

If the facility has been in operation for less than one year, the documentation of compliance with applicable fire code must be completed and signed by an architect licensed to practice in the state of Texas. Certification of such compliance must be based on the architect's inspection of the facility completed after (or immediately prior to) the facility begins operations.

10. Remodeled or renovated facilities.

For major remodeling and renovations, the facility must contract with an architect licensed to practice in the state of Texas. The architect must ensure that the remodel and renovation project adhere to local building code requirements.

11. Vehicles.

All vehicles used to transport individuals must be maintained in safe driving condition. in accordance with 37 TAC Chapter 23, Subchapter D (related to Vehicle Inspection, Items, Procedures, and Requirements).

a. Every vehicle used for transportation must have a fully stocked first aid kit and an A:B:C fire extinguisher that is easily accessible.
b. Any vehicle used to transport an individual must have appropriate insurance coverage.

12. Individual Safety.

The facility must ensure that:

a. All staff members are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;
b. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or to harm to a staff member;
c. Individual bedrooms, bathrooms, and other private or unsupervised areas used by individuals must be free of materials that could be utilized by an individual in an attempt to, or to die by suicide, or to harm or kill others. Such items include but are not limited to:
    i. Ropes;
    ii. Cords (including window blind cords);
    iii. Sharp objects;
    iv. Substances that could be harmful if ingested; and
    v. Extended ceiling fans.
d. Individual bedrooms, bathrooms, and other private or unsupervised areas must contain:
    i. Break-away curtains; and
    ii. Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.

N. Infection Control

1. Infection Control

Each facility must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

a. The facility must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
b. The facility must have written policies for the control of communicable disease in staff and individuals, which includes tuberculosis (TB) screening and provision of a safe and sanitary environment for individuals and staff.

2. TB reporting requirement.

The facility must maintain evidence of compliance with local and state health codes or ordinances regarding staff and individual health status.

a. Individuals. The name of any individual of a facility with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate

infection control procedures must be implemented as directed by the local health authority.

i. A facility must screen all individuals upon admission and after exposure to TB and provided follow-up as needed.
ii. HHSC will provide a TB screening questionnaire for admission screening: https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf

b. Employees. A facility employee that contracts a communicable disease that is transmissible to an individual through food handling or direct care, must be excluded from providing these services as long as a period of communicability is present.

i. The facility must screen all staff for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (for CDC) *Guidelines Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.
ii. All persons who provide services under an outside resource contract must, upon request of the facility, provide evidence of compliance with this requirement.

3. Universal Precautions.

Universal precautions must be used in the care of all individuals.

a. Staff who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.
b. First aid kits must be sufficient for the number of individuals served at the EOU.
i. Spill kits must be immediately accessible to all staff.
ii. Gloves must be immediately accessible to all staff.
iii. One-way, CPR masks must be immediately available to all staff.
iv. Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.
c. Sharps containers must be puncture resistant, leak proof, and labeled.
i. Sharps containers must not be overfilled.
ii. Needles in the sharps containers must not be capped or bent.
d. Disinfectants and externals must be separated from internals and injectables.
e. Running water or dry-wash disinfectant must be available to staff where sinks are not readily available.
f. Staff must be able to accurately describe:
i. The policy for handling a full sharps container;
ii. The actions to take if exposed to blood or body fluids;
iii. How to clean a blood or body-fluid spill; and
iv. Be able to direct a QM reviewer to all protective equipment.

4. Poison Control phone numbers must be posted throughout the EOU.

a. Information regarding Emergency Medical Treatment for Poisoning must be available to staff.

5. All medical materials must be stored and labeled on shelves or in cabinets in accordance with policies and procedures.
    a. The facility must maintain a record indicating that staff regularly checks the temperature in the refrigerator.
    b. There must be a thermometer in the refrigerator and temperatures must be maintained between 36 and 46 degrees Fahrenheit in accordance with 22 TAC Subchapter A, §291.15 (relating to Storage of Drugs).
    c. Refrigerators used to store medications must be kept neat, clean and free of non-pharmacy / non-medical items. Lab specimens must be stored separately.

O. Food Preparation and Food Service

When extended observation services are provided in a CSU or licensed hospital, food

preparation and food services must also follow licensing rules and regulations appropriate to the facility type.

1. Kitchen Standards

If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the individuals.

a. Kitchen or dietary area must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.
b. All facilities must provide a means for washing and sanitizing all dishes and cooking utensils.
c. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans, cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.
d. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.
e. In kitchens and laundries, staff must implement procedures to avoid cross-contamination between clean and soiled utensils and linens

2. Meals Availability

At least three meals or their equivalent must be:

a. Served daily;
b. Served at regular times; and
c. Provided with no more than a 16-hour span between a substantial evening meal and breakfast the following morning.

3. Nutrition and Diets

All facilities must:

a. Provide therapeutic or special diet when ordered;

b. Provide food and beverages to accommodate individuals who enter the facility after established meal times;
c. Ensure that menus provide a balances and nutritious diet, in accordance with the most recent version of the United States Department of Agriculture's guideline;
d. Accommodate individual kosher dietary needs or other related dietary practice
e. Maintain onsite at all times a four-day supply of staple foods and a one day supply of perishable foods.

4. Food Service

An EOU must meet the general food service needs of individuals receiving services. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.

a. Facilities that prepare meals in a centralized kitchen on site must:
    i. Pass an annual kitchen health inspection as required by law;
    ii. Immediately address any deficiencies found during any health inspection; and
    iii. Post the current food service permit from local health department.
b. Facilities that contract for food services must have a written contract that requires the food service to comply with the rules referenced in Information Item V. IV. Extended Observation Unit, N. Infection Control. The contracted food service must:
    i. Pass an annual kitchen health inspection as required by law;
    ii. Ensure the meals are transported to the EOU in temperature-controlled containers to ensure the food remains at the temperature at which it was prepared; and
    iii. Ensure that at least one staff, at minimum, maintains a current food handler's permit.

5. Food Storage

All facilities must ensure the:

a. Dating of food that is subject to spoilage; and
b. Supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period are maintained on premises.

V. Crisis Residential Services

A. Definition

Short-term, community-based residential, crisis treatment and services Provided by an LMHA or LBHA to children, adolescent and adult individuals experiencing behavioral health crises that cannot be stabilized in a less intensive setting. Crisis residential services are provided to individuals presenting with increased risk of harm to self or others or moderately severe functional impairment. Crisis residential facilities provide a safe environment with staff on site at all times. Individuals must present on a voluntary basis and have the ability to participate in treatment and services at a minimum level of engagement, as defined by the individual's treatment team. All crisis residential services must be delivered in accordance with Title 26 Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and 26 TAC Chapter 306, Subchapter D (relating to Mental Health Services—Admission, Continuity, and Discharge).

B. Goals

- Provide immediate crisis stabilization
- Provide a therapeutic environment to promote healing and restore sufficient functioning to allow the individual to transition to the least restrictive level of care
- Provide the individual with critical coping skills to support resilience and recovery
- Engage the individual with family, LAR, adult caregiver, identified support system and community resources and support
- Provide the individual with coordination of care and continuity of appropriate support services
- Reduce inpatient and law enforcement interventions through stabilization in the least restrictive setting

C. Description

1. Length of stay

The length of stay may vary depending on the clinical needs of an individual with the average length of stay being between six and ten days.

2. Admission criteria

Admission is voluntary and based upon medical necessity, as determined by an LPHA practicing within the scope of the LPHA's professional license. Crisis residential facilities do not accept individuals who are court-ordered or court-committed for treatment.

a. The facility must not admit individuals whose needs cannot be effectively addressed in the facility. Individuals requiring a greater or lesser level of care must be referred to a more appropriate level of care.
b. An individual must have enough medication on arrival to ensure psychiatric

and medical stabilization for at least three days. A Crisis Residential facility may admit an individual who does not have any medication on arrival only if the facility can provide a three-day supply of both psychiatric and physical medications within eight hours of admission.

c. An individual with capacity, as determined by a physician (i.e. preferably a psychiatrist), must give written consent to receive mental health services, including medication and laboratory services.

3. Egress

Crisis residential services must be provided in an unlocked facility that provides individual residents restricted entrance and unrestricted exit.

4. Facility standards

Crisis residential facilities must:

a. Remain open 24 hours a day, every day of the year;
b. Maintain trained and competent staff on site at all times to provide safety monitoring and reassessment to individuals receiving services; and
c. Maintain a stable and supportive environment that provides a venue for biological, psychological, and social interventions targeted at the current crisis while fostering community reintegration

5. Psychosocial programming

In accordance with 26 TAC Chapter 306, Subchapter F §306.321 (relating to Day Programs for Acute Needs), programming must be provided as clinically necessary in and focus on a range of topics that include, at a minimum:

a. reality orientation;
b. symptom reduction and management;
c. appropriate social behavior;
d. improving peer interactions;
e. improving stress tolerance;
f. the development of coping skills

D. Standards

1. Services Availability

a. This service must be available to individuals 24 hours a day, every day of the year. The availability of crisis residential services is dependent on LMHA or LBHA funding.
b. Admission of an individual to crisis residential must be determined by the LMHA or LBHA and based on medical necessity as determined by an LPHA.
c. When appropriate, the LPHA may use telemedicine or telehealth services to assess an individual for admission.

2. Staffing

a. Policies and Procedures. A psychiatrist must serve as the medical director for all crisis services and must approve all written procedures and protocols.

b. General Staffing Pattern. A written staffing plan must be available and address clinically indicated staffing adjustments based on the acuity and number of individuals served. The staffing plan must provide the following:

   i. An on-call roster of clinical (QMHP-CS and above) and nursing (RN and LVN) staff that is maintained and a process in place for assessing and anticipating staffing ensures clinical or nursing staff members are on-site at all times;

   ii. Staff coverage during the first and second shifts by trained and competent professional staff (i.e. QMHP-CSs);

   iii. Staff coverage used on third (i.e., overnight) shift may be trained and competent crisis support staff (i.e. non-licensed staff with less than a bachelor's degree in a human services field);

   iv. A sufficient number of staff trained and competent in verbal de-escalation intervention techniques available at all times;

   v. No fewer than two staff members, trained in verbal and physical management of assaultive or aggressive behavior, must be on site and available to respond at all times to ensure a safe environment;

   vi. A sufficient number of staff on site to provide one-on-one supervision of one or more individuals as indicated; and

   vii. A number of staff trained and competent in the verbal and physical management of assaultive or aggressive behavior which may be increased to a sufficient level to ensure the safety of all individuals and staff in the facility.

c. Day Programming for Acute Needs. Staffing of day programs must be provided to ensure safety and program adequacy per 26 TAC §306.321 (relating to Day Programs for Acute Needs).

d. Training, Competency and Credentialing.

   i. The competence of all staff must be continuously evaluated, monitored during the actual delivery of services, and continually enhanced to address the unique needs of individuals in different settings and situations.

   ii. Competency based expectations for all staff members are outlined in 26 TAC Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and include, but are not limited to:

      (1) Required competencies for all staff members;

      (2) Critical competencies for staff members whose primary job duties are related to individual service contacts and interactions;

      (3) Specialty competencies for staff who perform specialized services and tasks;

      (4) Telemedicine competencies for staff whose job duties are related to assisting telemedicine services; and

      (5) Competencies for staff providing crisis services.

iii. Licensing and credentialing of all staff must be monitored and verified prior to these staff providing services. Documentation of current credentialing and recredentialing should be maintained in the staff members' personnel records.

iv. Staff involved in assessment or treatment must receive crisis training that includes, but is not limited to:

(1) Identifying signs, symptoms, and crisis response related to a substance use;

(2) Identifying signs, symptoms, and crisis response to trauma, abuse, and neglect;

(3) Identifying signs, symptoms, and crisis response to individuals with intellectual disability and developmental disabilities;

(4) Identifying specialized assessment and intervention strategies for children, adolescents, and families;

(5) Assessing individuals and providing intervention;

(6) Conducting suicide screenings and assessments, homicide screenings and assessments, and risk of deterioration screenings and assessments;

(7) Applying knowledge and effective use of communication strategies such as a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, according to 25 TAC, Chapter 415, Subchapter F (relating to Interventions in Mental Health Services);

(8) Completing clinical interviews in behavioral health crisis care for staff, such as a physician (preferably a psychiatrist), Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), Physician's Assistant (PA), Licensed Practitioner of the Healing Arts (LPHA), or Qualified Mental Health Professional – Community Services (QMHP-CS); and

(9) Using telehealth or telemedicine technology, if applicable. Telemedicine and telehealth competencies must be included for positions in which a staff member's job duties are related to or involve assisting with telemedicine or telehealth services and include adequate and accurate knowledge of:

(a) operation of the telemedicine or telehealth equipment; and

(b) how to use the equipment to adequately present the individual.

e. Availability, Duties, and Responsibilities.

i. Staff on duty must remain awake and alert at all times.

ii. All facility staff trained and competent in verbal and physical management of assaultive/aggressive behavior must ensure the safety and wellbeing of all individuals and staff during the time a physician, PA, APRN, or RN is in route to provide needed services.

iii. Duties and responsibilities for all staff involved in the assessment or treatment of individuals must be:

(1) defined in writing by the medical director;

(2) appropriate to staff training, competency, and experience; and

(3) in conformance with the staff member's scope of practice and state standards for privileging and credentialing.

iv. LPHA

(1) An LPHA must be immediately available during the day and must be responsible for ensuring the individual is provided active treatment defined in an individualized crisis treatment plan.
(2) At least one LPHA must be available, either in person or through telehealth, to conduct patient interviews and initiate a full assessment within eight hours of presentation to the unit or sooner when indicated.

v. Physician

(1) Post admission, a physician (preferably a psychiatrist), PA, or APRN must see every individual at least once per week, or more frequently as clinically indicated and be on call 24 hours a day to evaluate individuals as needed and to provide supervision and consultation
(2) A process must exist to obtain medical and psychiatric medications, as needed, for the individual.
(3) A physician, (preferably a psychiatrist), PA, APRN, or RN must be on site or readily accessible to provide face-to-face services either in person or through telemedicine or telehealth services. If a physician is not already on site, the physician (preferably a psychiatrist), PA, or APRN must be available to provide face-to-face services, either in person or through telemedicine services, within one hour.

vi. Nursing staff

(1) An RN must be on call for emergencies, supervision, and consultation 24 hours a day, seven days a week.
(2) If a RN is not on site, the RN must be available to provide face-to-face services as soon as possible.

f. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

3. Assessment and Intake

a. Full Psychiatric Assessment

i. Individuals who present for crisis residential services must receive a full psychiatric assessment, either in person or through telemedicine services, by a physician (preferably a psychiatrist) APRN or PA within 24 after presentation unless:

(1) such assessment was conducted within the past 72 hours by an outpatient mental health provider, inpatient mental health facility or psychiatric emergency services provider and is available for review; and
(2) there are no recent changes to the individual's mental health status since the previous assessment was completed; or
(3) other observable indications that another full psychiatric assessment is warranted.

ii. A process must be developed and implemented to ensure that any individual requiring an immediate full psychiatric assessment due to increased risk of harm or deterioration can received such assessment within eight hours of initial presentation.

b. Assessment Process

i. The assessment process includes an attempt to determine an individual has an active Declaration for Mental Health Treatment and a biopsychosocial assessment which includes patient interview by QMHP-CSs, LPHAs or PAs;

ii. When indicated and as appropriate, telemedicine or telehealth services may be used to conduct assessments.

iii. The assessment process must include a review of available records of past treatment;

iv. The assessment process must gather and incorporate:

(1) Proactive history from family and collateral sources and in keeping with laws on confidentiality;

(2) Contact with the current behavioral health providers whenever possible and in keeping with laws on confidentiality;

(3) A diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;

(4) Identification of social, environmental, and cultural factors that may be contributing to the emergency;

(5) Documentation of the individual's ability and willingness to cooperate with treatment, as well as any treatment wishes listed in an individual's Declaration for Mental Health Treatment as applicable;

(6) A history of previous treatment and the response to that treatment including a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescribing practitioner;

(7) Documentation of an individual's current suicide risk, or plan; past suicidal ideations; past suicide attempts, and current access to means;

(8) Documentation of an individual's current feelings of violence towards others; plans for hurting others; access to means; and past violent behaviors;

(9) A general medical history that identifies all medical conditions that an individual has, and includes:

(a) Medical considerations of how these conditions affect the individual's overall current condition; and

(b) A review of symptoms focused on conditions that may present with psychiatric symptoms or cause cognitive impairment (e.g. a history of traumatic brain injury);

(10) A review of medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition;

(11) A detailed assessment of substance use conducted by an individual trained in assessing substance related disorders;

(12) An assessment for trauma, abuse or neglect by trained clinical staff, preferably an LPHA, with training in this assessment; and

(13) A physical health assessment as outlined below.

v. Physical Health Assessment

(1) Individuals must receive a physical health assessment by a physician (preferably a psychiatrist), PA. APRN, or RN, within two hours of entering a crisis residential unit unless:

(a) Such an assessment was already conducted within the last week; and

(b) There are no recent changes or other indications that another assessment may be warranted.

(2) Individuals not currently in services, or for whom the health status is unknown, must receive a comprehensive nursing assessment by an RN within 1 hour of presentation.

(3) The initial evaluation for physical health must be performed as ordered, by a physician (preferably a psychiatrist) or a APRN or PA and includes, at a minimum:

(a) Vital signs;

(b) A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;

(c) A screening neurological examination that is adequate to rule out significant acute pathology;

(d) A medical history and review of symptoms

(e) A pain assessment

(f) Screening for substance use and intoxication and, when indicated, screening for symptoms and complications of substance withdrawal;

(g) An assessment of medical and psychiatric stability and dangerousness to self or others; and

(h) An assessment of capacity to self-administer medications.

(i) Access to phlebotomy, urine collection, and laboratory studies must be provided. A written policy and procedure must be developed and implemented that defines how blood and urine specimens will be sent to a laboratory and how results will be transmitted back to the facility.

(4) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment must be provided.

vi. Orientation. Every individual admitted to services must receive a unit orientation no later than 24 hours after admission. In accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities). The orientation must explain orally and in writing, the individual's rights in a language and format easily understandable to the individual, and if applicable the individual's parent, LAR, or adult caregiver:

(1) Facility rules and expectations;

(2) The rights of individuals receiving treatment;

(3) The grievance policy;

(4) The schedule of program activities; and
(5) Determine that the individual comprehends the information provided in 1) - 4).

4. Interventions

a. Policies and Procedures. A written policy must be developed and implemented in accordance with 25 TAC Chapter 415, Subchapter F (relating to Interventions in Mental Health Services) that:
   i. Specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in service;
   ii. Identifies a process to obtain medical and psychiatric medications for individuals as needed;
   iii. Is reviewed and updated as needed; and
   iv. Is approved by the medical director.

b. Treatment Planning. Every individual admitted to services must participate in the development of a crisis treatment plan that delineates the most effective and least restrictive treatment for the individual's behavioral health disorder.
   i. This information will be shared with the individual and the individual's family, adult caregiver, LAR, or identified support system as appropriate.
   ii. The crisis treatment plan must be based on the provisional psychiatric diagnosis and must incorporate individual preferences.
   iii. The crisis treatment plan must incorporate individual preferences as reported or indicated in the individual's Declaration for Mental Health.

c. Treatment Interventions.
   i. An array of treatment interventions must exist in the crisis residential setting in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
      (1) A minimum of four hours per day of such programming must be available and must be provided to those who can participate at a minimal level of engagement as defined by the individual's treatment team.
      (2) Services should be goal-oriented and focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills. Services may consist of the following components:
         (a) Psychiatric nursing services,
         (b) Pharmacological instruction,
         (c) Symptom management training, and
         (d) Functional skills training.
      (3) The programming requirements may be fulfilled through the provision of individual crisis intervention services or by providing group services.
      (4) Group services may be delivered through the provision of services as specified in 26 TAC §306.321(relating to Day Programs for Acute Needs).

(5) Individuals who have significant co-occurring substance use must receive counseling designed to motivate the individual to continue substance use treatment following discharge from the program.

ii. Individuals must not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.

iii. The program must provide a stable therapeutic environment that includes:

(1) Consistently assigned unit personnel;

(2) Consistently scheduled unit activities;

(3) RN supervision or delegated staff supervision of an individual's self-administration of medication;

(4) Same-day access to medications available when needed; and

(5) Education on the psychotropic medication provided by the RN or QMHP-CS.

iv. In the event of a psychiatric emergency, regardless of consent, the individual may be administered emergency medication in accordance with25 TAC Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication—Mental Health Services).

5. Coordination of Treatment, Continuity of Care, and Discharge

a. A crisis residential unit must create and implement:

i. A written policy to ensure the provision of continuity of care and successful linkage with the referral facility, agency, or provider; and

ii. A written procedure defining the actions that must be taken to ensure every effort is made to contact existing treatment providers during the course of the individual's assessment and treatment in the service.

b. Coordination of services and continuity of care must be provided for every individual and must include:

i. identifying and linking the individual with all available services necessary to ensure transition to routine care; and

ii. providing necessary assistance in accessing those services, including contacting and coordinating with the individual's existing or newly selected service providers in a timely manner and in conformance with applicable confidentiality requirements.

c. Discharge planning must be initiated at the time of an individual's admission. In accordance with 26 TAC §301.201 (relating to Discharge Planning), a discharge plan must be developed for every individual, and must include:

i. Appropriate education relevant to the individual's condition;

ii. Information about the most effective treatment for the individual's behavioral health disorder;

iii. Identification of potential obstacles to a successful return to the community and means to address these obstacles; and

iv. Information about follow-up care, and appropriate linkages to post discharge providers.

6. Physical Plant

a. If the LMHA holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by HHSC, and any Quality Management and Compliance reviews will entail only programmatic elements.
b. If the LMHA owns and operates a non-licensed facility under an exemption from licensure they are required to register and submit a facility exemption form in conjunction with the Consolidated Local Services Plan submission every two years.
c. Crisis residential service units must provide a clean and safe environment.
d. Crisis residential services must create as normalized an environment as possible.
e. Crisis residential services units must not be designed to prevent elopement and must not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility.
f. All medications must be securely stored.

7. General Facility Environment

a. Water/Waste/Trash/Sewage.
    i. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
    ii. The water supply must be of safe, sanitary quality, suitable for use and adequate in quantity and pressure and must be obtained from a water supply system.
    iii. Waste, trash, and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
b. Windows. Operable windows must be insect screened.
c. Pest Control. An ongoing pest control program must be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals must be used.
d. Maintenance and Cleaning.
    i. In kitchens and laundries, facility staff must use procedures to avoid cross-contamination between clean and soiled utensils and linens.
    ii. The facility must be kept free of accumulations of dirt, rubbish, dust, and hazards.
    iii. Floors must be maintained in good condition and cleaned regularly.
    iv. Walls and ceilings must be structurally maintained, repaired, and repainted or cleaned as needed.

v. Storage areas and cellars must be kept in an organized manner.
vi. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
vii. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.

e. Telephone Access. There must be at least one telephone in the facility available to both staff and individuals for use in case of an emergency.

f. Temperature. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in individual-use areas.

g. Bedroom.
i. A bedroom must have no more than four beds.
ii. The facility must provide for each individual a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings.
iii. Furnishings provided by the facility must be maintained in good repair.

h. Bathroom.
i. At least one water closet, lavatory, and bathing unit must be provided on each sleeping floor accessible to individuals of that floor.
ii. One water closet and one lavatory for each six occupants, or fraction thereof, must be provided.
iii. One tub or shower for each ten occupants, or fraction thereof, must be provided.
iv. Privacy partitions and all curtains must be provided in water closets and bathing units in rooms for multi-individual use.
v. Tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
vi. Individual-use hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
vii. Individuals must have access to towels, soap, and toilet tissue at all times.

i. Storage.
i. The facility must provide sufficient and appropriate separate storage spaces or areas for the following:
(1) Administration and clinical records;
(2) Office supplies;
(3) Medications and medical supplies (these areas must be locked);
(4) Poisons and other hazardous materials (these must be kept in a locked area and must be kept separate from all food and medications);
(5) Food preparation (if the facility prepares food); and
(6) Equipment supplied by the facility for individual needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen

equipment etc.

ii. Storage must not be permitted in the attic spaces.

j. Food storage.

i. Food storage areas must provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.

ii. Food subject to spoilage must be dated.

k. Laundry.

i. A large facility (i.e., a facility with more than 16 beds) which co-mingles and processes laundry on-site in a central location must comply with the following:

(1) The laundry must be separated and provided with sprinkler protection if located in the main building (separation must consist of a one-hour fire rated partition carried to the underside of the floor or roof deck above);

(2) Access doors to the laundry area must be from the exterior of the facility or if from within the building by, way of non-individual use areas; and

(3) Soiled linen receiving, holding and sorting rooms must have a floor drain and forced exhaust to the exterior must operate at all times that soiled linen being held in this area.

ii. If laundry is processed off the site, the following must be provided on the premises: soiled linen holding room, clean linen receiving, holding, inspecting, sorting or folding, and storage room.

iii. Individual-use laundry, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.

l. Smoking. Regulations must be established and if smoking is permitted, outdoor smoking areas may be designated for individuals. Ashtrays of noncombustible material and safe design must be provided in smoking areas. Staff must not provide or facilitate individual access to tobacco products.

m. Room Space.

i. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms must be provided and have appropriate furniture.

ii. Dining areas must be provided and have appropriate furnishings.

8. Accessibility (ADA Compliance)

Crisis residential facilities must comply with the most recent versions of:

a. The Americans with Disabilities Acts Accessibility Guidelines;

b. The Texas Accessibility Standards in Texas Government Code, Chapter 469 (relating to Elimination of Architectural Barriers); and

c. All applicable sections of the Texas Administrative Code.

9. Postings

a. The facility must post in, near or within the medication room, a list of all staff members permitted to access the medication room.
b. The facility must post 911 as the emergency contact at, or within view, of the telephone.
c. The facility must ensure any permitted smoking areas are clearly marked as designated smoking areas.
d. The facility must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.
e. The facility must post an emergency evacuation floor plan.
f. The following must be prominently displayed in areas frequented by the consumers:
    i. Contact information for the Rights Protection Officer;
    ii. Contact information, including a toll-free number, and instructions for reporting abuse and neglect; and
    iii. Contact information stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
g. The facility postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.
h. A facility that prepares food on site must post the current food service permit from the local health department, if applicable.

10. Life Safety

a. Life Safety Code. The facility must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code. Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
b. Local Fire Code. The facility must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
c. Code Compliance. The facility must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
d. Emergency Evacuation Plan. The administration must have in effect, and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary.
    i. The plan must:
        (1) Include special staff actions, including fire protection procedures needed to ensure the safety of any resident;
        (2) Be amended or revised when needed;
        (3) Be readily available at all times within the facility;

(4) Require documentation that reflects the current evacuation capabilities of the individuals; and
(5) Include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the facility or during facility evacuation.

ii. All employees must be periodically instructed and kept informed with respect to their duties and responsibilities under the plan.

iii. The facility must conduct emergency evacuation drills quarterly and calculate evacuation scores in accordance with the fire code under which the facility is inspected.

e. Disaster Plan.

i. The administration must have in effect and available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, per 26 TAC, Chapter 301, Subchapter G, §301.312 (relating to Environment of Care and Safety).

ii. The written disaster plan must address, at a minimum, eight core functions:
(1) Direction and control;
(2) Warning;
(3) Communication;
(4) Sheltering arrangements;
(5) Evacuation;
(6) Transportation;
(7) Health and medical needs; and
(8) Resource management.

iii. The written disaster plan must include processes for identifying and assisting individuals as stated above in d.1) e) who have mobility limitations, or other special needs, who may require specialized assistance within the residential facility or during facility evacuation.

f. Recorded Inspections.

i. Facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections must be signed and dated.

ii. The following initial and annual inspections are required and must be kept on file:
(1) Local Fire safety inspections as outlined in 10.g., below;
(2) Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
(3) Annual local health authority kitchen inspection, if required;
(4) Fire extinguisher inspection and maintenance by personnel licensed or certified to perform the inspection; and
(5) Liquefied petroleum gas systems inspection by an inspector certified by the Texas Railroad Commission.

g. Fire Safety Inspections.
    i. Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal's Office.
    ii. The facility is responsible for arranging required inspections and ensuring that inspections are carried out in a timely manner.
    iii. The initial and ongoing fire safety reports must be signed by the certified inspector performing the inspection.
    iv. These reports must be kept on file and be readily available for review by the state.
    v. All fires causing damage to the crisis residential unit or to equipment must be reported to the HHSC Contract Manager within 72 hours. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Report must be made by telephone during normal business hours and by telephone call and e-mail during other times, with a follow-up telephone call to the Contract Manager on the first business day following the event.
    vi. Open flame heating devices are prohibited. All fuel burning heating devices must be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.

h. Correction Plan. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff must take immediate corrective action to bring the facility into compliance with the applicable code.
    i. The facility must have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions.
    ii. The facility must have on file documentation by the Certified Fire Inspector that all findings have been corrected and that the facility is in full compliance with all applicable codes.
    iii. During the period of corrective action, the facility must take any steps necessary to ensure the health and safety of individuals residing in the facility during the time repairs or corrections are being completed.

i. Newly Operational Facilities. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in the State of Texas. Such certification must be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a crisis residential facility.

j. Pre-operational facility requirements. Any newly constructed or renovated or remodeled unlicensed crisis residential facility must receive a preoperational on-site review by HHSC QM before being open to the public to provide crisis residential services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.

k. Individual Safety. The LMHA or LBHA must ensure that:
   i. All staff members are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;
   ii. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or harm to a staff member;
   iii. Individual bedrooms, bathrooms and other private or unsupervised areas must be free of materials that could be utilized by an individual to attempt, or to die by suicide, or to harm or kill others, such as, but are not limited to:
      (1) Ropes;
      (2) Cords (including window blind cords);
      (3) Sharp objects;
      (4) Substances that could be harmful if ingested; and
      (5) Extended ceiling fans.
   iv. Individual bedrooms, bathrooms and other private or unsupervised areas must contain:
      (1) Break-away curtains; and
      (2) Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.

l. Vehicle Safety.
   i. All vehicles used to transport individuals must be maintained in safe driving condition, in accordance with 37 TAC Chapter 23, Subchapter D (relating to Vehicle Inspection Items, Procedures, and Requirements)
   ii. Any vehicle used to transport an individual must have appropriate insurance.
   iii. Every vehicle used for individual transportation must have an easily accessible fully stocked first aid kit and an A:B:C type fire extinguisher.

11. Infection Control

a. Infection Control.
   i. Each facility must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
   ii. The facility must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-related Facilities).
   iii. The facility must have written policies for the control of communicable disease in employees and individuals, which includes tuberculosis (TB) screening and provision of a safe and sanitary environment for individuals and employees.

b. TB Reporting Requirement. The facility must maintain evidence of compliance with local and/or state health codes or ordinances regarding employee and individual health status.
   i. Individuals. The name of any individual of a facility with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of

Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.

(1) All individuals must be screened upon admission and after exposure to TB and provided follow-up as needed.

(2) HHSC will provide TB screening questionnaire for admission screening: https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf

ii. Employees. If employees contract a communicable disease that is transmissible to individuals through food handling or direct individual care, the employee must be excluded from providing these services as long as a period of communicability is present.

(1) The facility must screen and test all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.

(2) All persons who provide services under an outside resource contract must, upon request of the facility, provide evidence of compliance with this requirement.

c. Universal Precautions. Personnel who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.

i. Universal precautions must be used in the care of all individuals.

ii. First Aid Kits must be sufficient for the number of individuals served at the site.

(1) Gloves must be immediately accessible to all staff.

(2) One-way, CPR masks must be immediately available to all staff.

(3) Spill Kits must be immediately accessible to all staff.

iii. Sharps containers must be puncture resistant, leak proof and labeled.

(1) Sharps containers must not be overfilled.

(2) Needles in the sharps containers must not be capped or bent.

iv. Disinfectants and externals must be separated from internals and injectables.

(1) Medications requiring special climatic conditions (e.g. refrigeration, darkness, tight seal, etc.) must be stored properly.

(2) The refrigerator must have a thermometer.

(3) Recorded refrigerator temperatures must be maintained between 36 and 46 degrees Fahrenheit, in accordance with 22 TAC §291.15 (related to Storage of Drugs).

v. Running water or dry-wash disinfectant must be available to staff where sinks are not easily available.

vi. Staff must demonstrate ability to accurately describe the policy for handling a full sharps container.

(1) Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.

(2) Staff must be able to describe the actions to take if exposed to blood or body fluids.
(3) Staff must be able to describe how to clean a blood or body-fluid spill.
(4) Staff must be able to direct QM reviewer to all protective equipment.

vii. Poison Control phone numbers must be posted throughout the facility and information regarding Emergency Medical Treatment for Poisoning must be available to staff.

viii. All medical materials must be properly stored on shelves or in cabinets that must be correctly labeled.

d. Animal Safety. Animals housed at the facility or visiting the facility must be properly vaccinated and supervised.

12. Medication Management

a. Medication Storage. All facilities that provide or store an individual's medication during the length of stay must implement written procedures for medication storage, administration, documentation, controlled substances, inventory, and disposal in accordance with 26 TAC Chapter 301, Subchapter G, §301.355, (relating to Medication Services). An LMHA must ensure that:
   i. Individuals do not retain any of their personal medications while in the facility;
   ii. Individuals receive their personal medications upon discharge from the facility;
   iii. Medications that are kept on-site are kept locked at all times; and
   iv. Staff are able to provide a copy of the most recent medication stock inspection.

b. Climate Controlled Medications.
   i. The facility must maintain a record indicating that staff regularly checks the temperature in the refrigerator.
   ii. Refrigerators used to store medications must be kept neat, clean and free of non-pharmacy and non-medical items. Lab specimens must be stored separately.

c. Labelling Medications.
   i. The facility must ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.
   ii. Medication labels must not be handwritten or changed.

d. Controlled Substances.
   i. Controlled substances must be approved by a physician employed by or contracting or subcontracting with the LMHA or LBHA that operates the facility.
   ii. An inventory of controlled substances must include:
      (1) Whether the inventory was taken at the beginning or close of business;
      (2) Name of controlled of substances;
      (3) Each finished form of the substances (e.g. 100mg tablet);
      (4) The number of dosage units of each finished form in the

commercial container (e.g. 100 tablet bottle);

(5) The number of commercial containers of each finished form (e.g. four 100 tablet bottles); and

(6) Controlled substances must be stored under double locks.

e. Facility Management.

i. The facility management must:

(1) Ensure that only licensed medical staff members have access to medications administered to individuals;

(2) Maintain in the medication room a current list of all LMHA, LBHA or subcontracted practitioners who are authorized to prescribe the medications that are administered from the residential facility medication room;

(3) Maintain a current list in the medication room of all staff allowed to administer medications to individuals;

(4) Maintain a current list in the medication room of all non-licensed, trained staff allowed to observe self-administration of medications; and

(5) Ensure that staff does not transfer medications from one container to another; individuals may independently transfer their own medications from a bottle to a daily medication reminder.

ii. The facility must ensure that staff members have readily available access to a hardcopy or digital format of a medication guide (such as the Physician's Desk Reference or similar publication) in a version that is no more than two years old.

iii. The facility must maintain an Emergency Medication Kit.

(1) The medications in the emergency medication kit must be monitored with a perpetual inventory and make use of breakaway seals.

(2) The medication kit must contain medications and other equipment as specified by the facility medical director. This generally includes, but is not limited to, short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications.

iv. There must be evidence in the clinical records that individuals are educated about their medications whenever medications are prescribed or changed.

13. Food Preparation and Food Service

a. Inspections. If the facility prepares meals in a centralized kitchen on site, it must pass an annual kitchen health inspection as required by the local health department, as applicable. The facility must:

i. Immediately address any deficiencies found during any health inspection.

ii. Post the current food service permit from the local health department.

b. Kitchen Standards.

i. If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the individuals.

ii. It must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.
iii. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.
iv. All facilities must provide a means for washing and sanitizing dishes and cooking utensils must be provided.
v. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.
vi. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.

c. Meal Preparation.
i. In facilities that prepare meals for individuals, at least three meals or their equivalent must:
(1) Be served daily;
(2) At regular times;
(3) With no more than a 16-hour span between a substantial evening meal; and
(4) Breakfast the following morning.
ii. In facilities where individuals prepare their own food:
(1) The facility must ensure that a variety of foods are available for each meal to allow individuals to have a choice of foods for to prepare for each meal;
(2) The facility must ensure that the foods available are nutritious and well balanced, such as those recommended by the United States Department of Agriculture and must accommodate individual kosher dietary needs or other related dietary practice;
(3) Food for at least three meals must be provided daily for individuals to prepare;
(4) If individuals require special dietary items, the facility must ensure that such items are provided to the individual; and
(5) Regular food preparation and mealtimes must be established by the facility.

d. Nutrition and Diets.
i. Therapeutic diets must be provided to individuals when ordered by a physician.
ii. In facilities that prepare food for the individuals, the menus must be prepared to provide a balanced and nutritious diet, such as those recommended by the United States Department of Agriculture, and must accommodate individual Kosher dietary needs or other related dietary practice.

e. Availability. In all facilities, food and beverage must be available to accommodate individuals who enter the facility after established meal times.

f. Food Storage. In all facilities, supplies of staple foods for a minimum of a

four-day period and perishable foods for a minimum of a one-day period must be maintained on premises. Food subject to spoilage must be dated.

g. Food Service.
   i. When meals are provided by a food service, a written contract must require the food service to:
      (1) Comply with the rules referenced in Information Item V. V. Crisis Residential Services. 13. Food Preparation and Food Service; and
      (2) Pass an annual kitchen health inspection as required by law.
   ii. The facility must ensure the meals are transported to the facility in temperature-controlled containers to ensure the food remains at the temperature at which it was prepared.
   iii. The facility must ensure that at least one facility staff, at minimum, maintains a current food handler’s permit.

VI. Crisis Respite Services

A. Definition

Crisis respite services provide short-term, community-based residential, crisis treatment to individuals who have low risk of harm to self or others and may have some presence functional impairment, and who require direct supervision and care, but do not require hospitalization. The primary objective of crisis respite services is stabilization and resolution of a crisis situation for the individual and/or the individual's caregiver(s). All crisis respite services must be delivered in accordance with Title 26 Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Mental Health Community Services Standards) and 26 TAC Chapter 306, Subchapter D (relating to Mental Health Services—Admission, Continuity, and Discharge).

These services can occur in houses, apartments, group and foster homes, the individual's own home, or other community living situations. Crisis respite services may serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the individual for whom they care to help that individual avoid a mental health crisis. Utilization of these services is managed by the LMHA or LBHA based on medical necessity. The availability of facility-based respite units is dependent on LMHA or LBHA funding.

B. Goals

- Provide immediate crisis stabilization
- Restore sufficient functioning to allow the individual to transition to the least restrictive level of care
- Provide the individual with critical coping skills to support resilience and recovery
- Engage the individual with family, caregivers, and LARs or identified support system and community resources and support
- Provide the individual with coordination of care and continuity of appropriate recovery support services.
- Reduce inpatient and law enforcement intervention through stabilization in the least restrictive environment.

C. Description

1. Length of Stay

The length of stay may vary depending on the clinical needs of an individual with the average length of stay being between a few hours to ten days.

2. Admission Criteria.

Individuals considered for admission into crisis respite services:

a. Must be at risk of psychiatric crises due to severe stressors in their

environment but are at low risk of harm to self or others;
b. Must have the ability to perform their own activities of daily living with staff support;
c. May have mild functional impairment but must be able to cooperate with staff support;
d. Must be capable of self-administering medications with staff support;
e. Must have enough medications upon arrival to ensure psychiatric and medical stabilization for the expected length of stay;
f. May have mild medical co-occurring diagnoses, as specified and approved by the facility medical director, if the medical condition is stable with prescribed and available medications;
g. May have co-occurring psychiatric and substance use disorders (COPSD)that result in no more than mild impairment; and
h. Must have low risk for elopement if the individual is a child or adolescent.

3. Egress.

Crisis respite services must be provided in an unlocked facility that provides individual residents restricted entrance and unrestricted exit. Facilities may utilize exits with delayed egress.

4. Facility Standards.

Crisis respite facilities must:

a. Separate children and adolescents from adults and further separate children from adolescents according to age and developmental needs, unless there is documented clinical or developmental justification;
b. Create a stable and supportive environment with limited supervision provided by trained and competent staff;
c. Create and implement procedures to obtain medications for individuals when needed.
d. Ensure compliance with the minimum standards in 26 TAC Chapter 748 (relating to Minimum Standards for General Residential Operations), except for those minimum standards identified for specific types of services that the operation does not offer when child and adolescent crisis respite services are provided in a general residential operations environment.

5. Psychosocial Programming.

This stable and supportive environment provides a venue for biological, psychological, and social interventions targeted at the current crisis while fostering community reintegration.

a. During facility-based respite, individual and group skills training are provided and are based on the needs of the individual and the goals of their individualized crisis treatment plans. Individuals may be provided support from peer specialists and connection to recovery support services.

b. When child and adolescent crisis respite services are provided in a free-standing facility operated by a LMHA or LBHA, facility standards are the same as those listed in Information Item V. VI. Crisis Respite Services 5. Psychosocial Programming
c. When child and adolescent crisis respite services are provided in a general residential operations environment, the respite provider must ensure programming includes:
    i. Provision of educational services as recommended by the clinical team and in accordance with 26 TAC Chapter 748, Subchapter I, Division 3 (relating to Educational Services);
    ii. Ensure that the use of television, online videos, computers, or video game systems as an activity for children and adolescents:
        (1) Are age-appropriate;
        (2) Do not exceed two hours per day; and
        (3) Are not used to replace the psychosocial programming activities
    iii. Provision of opportunities for recreational activities and physical fitness in accordance with general requirements listed in 26 TAC, Chapter 748, Subchapter Q, Division 1 (relating to General Requirements).

D. Standards

1. Services Availability

a. When offered, this service must be available 24 hours a day, every day of the year and respite services must be made available to individuals throughout the local service area.
b. Admission to crisis respite must be determined by the LMHA or LBHA and must be based on a medical necessity determination by an LPHA.

2. Staffing for Facility-based Crisis Respite

a. Policies and Procedures. A psychiatrist must serve as the medical director for all crisis services and must approve all written procedures and protocols.
b. General Staffing Pattern.
    i. The crisis support staff must be trained, competent, and on site 24 hours a day.
    ii. The respite program must develop and implement a process for assessing and anticipating staffing needs.
    iii. The crisis support staff must be scheduled in sufficient numbers to ensure individual and staff safety during the provision of needed services.
c. Training, Competency and Credentialing. The LMHA or LBHA must:
    i. Ensure that services are provided by staff members who are operating within the scope of their license, credentialing, job description, or contract specification;
    ii. Define competency-based expectations for each respite facility staff position;

iii. Ensure each staff member receives initial training before the staff member assumes crisis respite responsibilities and annually throughout the staff member's employment with the respite facility;
iv. Require all staff members to demonstrate:
(1) required competencies in accordance with 26 TAC §301.331(a)(3)(A) (relating to Required Competencies); and
(2) critical competencies for topics delineated in 26 TAC §301.331(a)(3)(B) (relating to Critical Competencies).
v. Ensure that crisis support staff members providing in-home crisis respite services receive the additional training and display the additional competencies required to provide crisis services to children and adolescents.

d. Availability, Duties, and Responsibilities.
i. Staff members on duty must remain awake and alert at all times.
ii. The facility must develop and implement policies and procedures allowing on-site staff members to obtain 24-hour access to supervision, consultation, and evaluation when needed from:
(1) A physician (preferably a psychiatrist), a PA, an APRN, or an RN for medical emergencies; and
(2) An RN or LPHA for clinical emergencies.
iii. Duties and responsibilities for all staff involved in the assessment or treatment of individuals must be:
(1) Defined in writing by the medical director;
(2) Appropriate to staff training, competency, and experience; and
(3) In conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.

e. When child and adolescent crisis respite services are provided in a general residential operations environment, crisis respite providers must adhere to:
i. Facility staff standards listed in 26 TAC Chapter 748, Subchapter G (relating to Child/Caregiver Ratios); and
ii. Staff training and professional development 26 TAC Chapter 748,
iii. Subchapter F (relating to Training and Professional Development).

f. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

3. Assessment and Intake

a. Individuals must receive a full crisis assessment by a physician (preferably a psychiatrist) or a PA, APRN, LPHA, RN, or QMHP-CS, prior to admission to crisis respite services and must include an attempt to determine an individual has an active Declaration for Mental Health Treatment
b. Individuals in respite services must be provided immediate access to urgent and emergent non-psychiatric medical assessment and treatment when needed.

c. Every child, adolescent, and adult admitted to crisis respite services, as well as the individual's parent, LAR, or adult caregiver, as applicable, receives a unit orientation from an appropriately trained staff member no later than 24 hours after admission.
d. The respite unit or service provider must ensure that the staff member providing intake and orientation:
    i. Explains orally, and provides in writing, in a language and format easily understandable to the individual, and their parent, LAR, or adult caregiver, as applicable;
        (1) The individual rights, as addressed in 25 TAC, §404.161 (relating to Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers);
        (2) The child or adolescent's special rights, in accordance with 26 TAC Chapter 748, Subchapter H (relating to Child Rights);
        (3) The facility's or operation's grievance policy;
        (4) The facility's or operation's rules and expectations;
        (5) The facility's or operation's schedule of programs; and
    ii. Determines that the individual, and their parent, LAR, or adult caregiver, as applicable, comprehends the information provided in item a).
e. When child and adolescent crisis respite services are provided in general residential operations, crisis respite providers must adhere to the following additional assessment and intake standards:
    i. Complete a placement agreement with a child or adolescent, and their parent, LAR, or adult caregiver, as applicable, that defines the service provider's roles and responsibilities, and authorizes the provision of services for the child or adolescent. The placement agreement must include:
        (1) Authorization permitting the service provider to care for the child or adolescent;
        (2) A medical consent form signed by a person legally authorized by the Texas Family Code to provide consent; and
        (3) c) The reason for placement and anticipated length of time in care.
    ii. Staff members gathering preadmission information must adhere to standards in 26 TAC Chapter 748, Subchapter S, (relating to Respite Child-Care Services), including obtaining pre-admission continuity of care information listed in §748.4265 (relating to What information regarding a child must I receive prior to providing respite child-care services to that child?);
    iii. Staff members conducting admission assessments for children and adolescents needing emergency care services, including respite child-care services, must adhere to standards in 26 TAC §748.4231 (relating to What information must an admission assessment include for a child needing emergency care services, including respite child-care services?).

4. Interventions for Facility-based Crisis Respite

a. Behavioral Health Emergencies. A written policy must be developed and implemented in accordance with 25 TAC Chapter 415, Subchapter F (relating to Interventions in Mental Health Services) that:
   i. Is approved by the medical director;
   ii. Specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the service;
   iii. Outlines ways to access appropriate immediate care to stabilize a behavioral health emergency (e.g., to prevent harm to the individual or to others); and
   iv. Is reviewed and updated as needed.

b. Treatment Planning. An individual crisis treatment plan must be followed for everyone. The crisis treatment plan must incorporate individual preferences as reported or indicated in the individual's Declaration for Mental Health. This information must be shared with the individual and the individual's parent, LAR, adult caregiver, or identified support system as appropriate. The facility must develop and implement a written procedure that crisis support staff members:
   i. Provide daily documentation on an individual's progress on treatment goals;
   ii. Document progress on the format approved by facility administrator; and
   iii. Communicate daily documentation to the credentialed staff member, at minimum as a QMHP-CS, responsible for making updates to the individual crisis treatment plan and making recommendations to continue services, change current services, or discharge from services. The credentialed staff member may be located or work from a location outside of the crisis respite facility.

c. Treatment Interventions. An array of treatment interventions must be provided in the crisis respite setting to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
   i. Services should be goal-oriented and based on the individual's needs and individualized crisis treatment plan. Services should focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills; and may consist of the following component services:
      (1) Psychiatric nursing services,
      (2) Pharmacological instruction,
      (3) Symptom management training, and
      (4) Functional skills training.
   ii. The programming requirements may be fulfilled through the provision of individual crisis intervention services or by providing group services.
   iii. Group services may be delivered by level of care assignment or through the provision of Day Programs for Acute Needs as specified in 26 TAC Chapter 306, Subchapter F (relating to Mental Health Rehabilitative Services).

iv. Individuals who have significant co-occurring substance use disorder must receive counseling designed to motivate the individual to continue with substance use disorder treatment following discharge from the program.

d. Individuals must not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.

e. Facility-based crisis respite units must maintain a stable therapeutic environment that includes assigned personnel and scheduled activities.

f. When child and adolescent crisis respite services are provided in general residential operations, crisis respite providers must adhere to the following additional standards for:

i. Child and adolescent assessments, in 26 TAC Chapter 748, Subchapter T (Additional Requirements for Operations That Provide an Assessment Services Program), when the service provider conducts assessment services;

ii. Child and adolescent crisis respite services provided to pregnant and parenting children and adolescents, in 26 TAC Chapter 748, Subchapter J, Division 10 (relating to Additional Requirements for Pregnant and Parenting Children); and

iii. Child and adolescent crisis respite services provided to individuals with COPSD issues, in accordance with 26 TAC §448.906 (relating to Access to Services for Co-Occurring Psychiatric and Substance Use Disorders (COPSD) Clients).

5. Coordination and Continuity of Care

a. A crisis respite unit must create and implement:

i. Written policy to ensure the provision of continuity of care and successful linkage with the referral facility, agency or provider; and

ii. Written procedure defining the actions that must be taken to ensure every effort is made to contact existing treatment providers during the individual's assessment and treatment in the service.

b. Coordination of services and continuity of care must be provided for every individual and must include:

i. Identifying and linking the individual with all available services necessary to ensure transition to routine care; and

ii. Providing necessary assistance in accessing those services, including contacting and coordinating with the individual's existing or newly selected service providers in a timely manner and in conformance with applicable confidentiality requirements.

c. Discharge planning must be initiated at the time of an individual's admission. In accordance with 26 TAC §306.201 (relating to Discharge Planning), a discharge plan must be developed for every individual, and must include:

i. Appropriate education relevant to the individual's condition;

ii. Information about the most effective treatment for the individual's behavioral health disorder;

iii. Identification of potential obstacles to a successful return to the living situation of the individual's choice and means to address these obstacles; and
iv. Information about follow-up care, and appropriate linkages to post discharge providers.

d. When child and adolescent crisis respite services are provided in general residential operations, crisis respite providers must adhere to 26 TAC Chapter 748, Subchapter I (relating to Admission, Service Planning, and Discharge) standards related to emergency and non-emergency:
   i. Admission;
   ii. Service Planning;
   iii. Discharge and transfer planning; and
   iv. Release of a child or adolescent.

6. Physical Plant

a. The physical plant must have written policies and procedures for monitoring environmental safety, in accordance with 26 TAC §301.312 (relating to Environment of Care and Safety).
b. Any new crisis respite unit must receive a preoperational, on site Quality Management (QM) review before being open to the public to provide services.
c. The crisis respite unit is subject to HHSC QM reviews. Any changes in programming, construction or facility must be reported to the HHSC Contracts Management department immediately. For facility-based crisis respite, if the LMHA or LBHA holds an Assisted Living
d. A Type A licensed facility will be accepted as "deemed status" by HHSC, meaning:
   i. Any Quality Management and Compliance reviews will entail only programmatic elements; and
   ii. Any Regulatory Compliance inspection and survey will occur in accordance with assisted living licensing standards located in 26 TAC §301.312 (relating to Environment of Care and Safety).
e. If the LMHA owns and operates a non-licensed facility under an exemption from licensure they are requires to register and submit a facility exemption form in conjunction with the Consolidated Local Services Plan submission every two years.
f. The facility must provide a clean and safe environment.
g. The facility must create a stable and supportive environment.
h. Crisis respite units are not designed to prevent elopement and must not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility. Crisis respite units may use exits with delayed egress.
i. All medications must be securely stored.
j. Contracted residential treatment centers or foster care homes that serve

children and are used for crisis respite are subject to licensing regulations of the Department of Family and Protective Services.

7. General Facility Environment

When crisis respite services are provided at a residential or crisis triage facility, or at a stand-alone facility, the facility must meet the following standards:

a. Water/Waste/Trash/Sewage.
   i. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
   ii. The water supply must be of safe, sanitary quality, suitable for use and adequate in quantity and pressure and must be obtained from a water supply system.
   iii. Waste, trash, and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).

b. Windows. Operable windows must be insect screened.

c. Pest Control. An ongoing pest control program must be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals must be used.

d. Maintenance and Cleaning.
   i. In kitchens and laundries, facility staff must use procedures to avoid cross-contamination between clean and soiled utensils and linens.
   ii. The facility must be kept free of accumulations of dirt, rubbish, dust, and hazards.
   iii. Floors must be maintained in good condition and cleaned regularly.
   iv. Walls and ceilings must be structurally maintained, repaired, and repainted or cleaned as needed.
   v. Storage areas and cellars must be kept in an organized manner.
   vi. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
   vii. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.

e. Telephone Access. There must be at least one telephone in the facility available to both staff and individuals for use in case of an emergency.

f. Temperature. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in individual-use areas.

g. Bedroom.

i. A bedroom must have no more than four beds.
ii. The facility must provide for each individual a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings.
iii. Furnishings provided by the facility must be maintained in good repair.

h. Bathroom.
i. At least one water closet, lavatory, and bathing unit must be provided on each sleeping floor accessible to individuals of that floor. One water closet and one lavatory for each six occupants, or fraction thereof, must be provided. One tub or shower for each ten occupants, or fraction thereof, must be provided.
ii. Privacy partitions and all curtains must be provided in water closets and bathing units in rooms for multi-individual use.
iii. Tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
iv. Individual-use hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
v. Individuals must have access to towels, soap, and toilet tissue at all times.

i. Storage.
i. The facility must provide sufficient and appropriate separate storage spaces or areas for the following:
(1) Administration and clinical records;
(2) Office supplies;
(3) Medications and medical supplies (these areas must be locked);
(4) Poisons and other hazardous materials (these must be kept in a locked area and must be kept separate from all food and medications);
(5) Food preparation (if the facility prepares food); and
(6) Equipment supplied by the facility for individual needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment etc.
ii. Storage must not be permitted in the attic spaces.

j. Food storage.
i. Food storage areas must provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
ii. Food subject to spoilage must be dated.

k. Laundry.
i. A large facility (i.e., a facility with more than 16 beds) which co-mingles and processes laundry on-site in a central location must comply with the following:
(1) The laundry must be separated and provided with sprinkler protection if located in the main building (separation must consist of a one-hour fire rated partition carried to the underside of the floor or roof deck above);

(2) Access doors to the laundry area must be from the exterior of the facility or if from within the building by, way of non-individual use areas; and

(3) Soiled linen receiving, holding and sorting rooms must have a floor drain and forced exhaust to the exterior must operate at all times that soiled linen being held in this area.

ii. If laundry is processed off the site, the following must be provided on the premises: soiled linen holding room, clean linen receiving, holding, inspecting, sorting or folding, and storage room.

iii. Individual-use laundry, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.

l. Smoking. Regulations must be established and if smoking is permitted, outdoor smoking areas may be designated for individuals. Ashtrays of noncombustible material and safe design must be provided in smoking areas. Staff must not provide or facilitate individual access to tobacco products.

m. Room Space.

i. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms must be provided and have appropriate furniture.

ii. Dining areas must be provided and have appropriate furnishings.

n. The respite services providers must meet physical site minimum standards listed in 26 TAC Chapter 748, Subchapter P (relating to Physical Site) when child and adolescent crisis respite services are provided in general residential operations.

8. Accessibility (ADA Compliance)

Crisis respite facilities must comply with the most recent versions of:

a. The Americans With Disabilities Acts Accessibility Guidelines;
b. The Texas Accessibility Standards in Texas Government Code, Chapter 469, (relating to Elimination of Architectural Barriers); and
c. All applicable sections of the TAC.

9. Postings

a. The facility must post near, or within the medication room, a list naming all staff members permitted access to the medication room.
b. The facility must post 911 as the emergency contact at, or within view, of the telephone.
c. The facility must ensure that designated smoking areas are clearly marked.
d. The facility must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.
e. The facility must post an emergency evacuation floor plan.

f. The following must be prominently displayed in areas frequented by individuals:
   i. Contact information for the Rights Protection Officer,
   ii. Contact information, including a toll-free number, and instructions for reporting abuse and neglect;
   iii. Contact information stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
g. A facility that prepares food must post the current food service permit from the local health department, if applicable.
h. The facility postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area; and
i. The respite provider must ensure the additional posting requirements listed in 26 TAC §748.191 (relating to What items must I post at my operation?) when child and adolescent crisis respite services are provided in a general residential operations environment. The following items must be posted in a prominent and public place that is accessible for staff members, children, parents, and others to view at all times:
   i. The operation's permit, posted at the main office location;
   ii. The HHSC Licensing notice, Keeping Children Safe; and
   iii. Emergency and evacuation relocation plans posted in each building and living quarters used by children and adolescents.

10. Life Safety

j. Life Safety Code. The facility must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code. Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
k. Local Fire Code. The facility must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
l. Code Compliance. The facility must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
m. Emergency Evacuation Plan. The LMHA or LBHA must develop, implement and make available to all supervisory personnel, written copies of a plan for the protection of all individuals in the event of fire.
   i. The plan must:
      (1) Include details on safely evacuating individuals from the building to areas of refuge;
      (2) Include details on sheltering in place when appropriate;
      (3) Include special staff actions including fire protection procedures needed to ensure the safety of any individual;
      (4) Be amended or revised when needed;

(5) Be readily available at all times within the facility; and
(6) Require documentation that reflects the current evacuation capabilities of the individuals

ii. All employees must be periodically instructed and kept informed with respect to their duties and responsibilities under the plan.

iii. The facility must conduct emergency evacuation drills quarterly and calculate evacuation scores in accordance with the fire code under which the facility is inspected.

n. Disaster Plan.

i. The LMHA or LBHA must have in effect and available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, per 26 TAC, Chapter 301, Subchapter G, §301.312 (relating to Environment of Care and Safety).

ii. The written disaster plan must address, at a minimum, eight core functions:
(1) Direction and control;
(2) Warning;
(3) Communication;
(4) Sheltering arrangements;
(5) Evacuation;
(6) Transportation;
(7) Health and medical needs; and
(8) Resource management.

iii. The written disaster plan must include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the respite facility or during facility evacuation.

o. Recorded Inspections.

i. Facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections must be signed and dated.

ii. The following initial and annual inspections are required and must be kept on file:
(1) Local Fire safety inspections as outlined in 10.g., below;
(2) Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
(3) Annual kitchen inspection by the local health authority, if applicable;
(4) Fire extinguisher inspection and maintenance by personnel licensed or certified to perform the inspection; and
(5) Liquefied petroleum gas systems inspection by an inspector certified by the Texas Railroad Commission.

p. Fire Safety Inspections.

i. Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal's Office.
ii. The facility is responsible for arranging required inspections and ensuring that inspections are carried out in a timely manner.
iii. The initial and ongoing fire safety reports must be signed by the certified inspector performing the inspection.
iv. These reports must be kept on file and be readily available for review by the state.
v. All fires causing damage to the crisis residential unit or to equipment must be reported to the HHSC Contract Manager within 72 hours. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Report must be made by telephone during normal business hours and by telephone call and e-mail during other times, with a follow-up telephone call to the Contract Manager on the first business day following the event.
vi. Open flame heating devices are prohibited. All fuel burning heating devices must be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.

q. Correction Plan. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff must take immediate corrective action to bring the facility into compliance with the applicable code.
i. The facility must have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions.
ii. The facility must have on file documentation by the Certified Fire Inspector that all findings have been corrected and that the facility is in full compliance with all applicable codes.
iii. During the period of corrective action, the facility must take any steps necessary to ensure the health and safety of individuals residing in the facility during the time repairs or corrections are being completed.

r. Newly Operational Facilities. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in Texas. Such certification must be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a crisis residential facility.

s. Pre-operational facility requirements. Any newly constructed or renovated or remodeled unlicensed crisis residential facility must receive a preoperational on-site review by HHSC QM before being open to the public to provide crisis residential services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.

t. Evacuation Plan. All facilities must post emergency evacuation floor plans.

u. Individual Safety. The administrator of each facility must ensure that:
   i. All staff members are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;
   ii. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or harm to a staff member;
   iii. Individual bedrooms, bathrooms and other private or unsupervised areas must be free of materials that could be utilized by an individual to attempt, or to die by suicide, or to harm or kill others, such as, but are not limited to:
      (1) Ropes;
      (2) Cords (including window blind cords);
      (3) Sharp objects;
      (4) Substances that could be harmful if ingested; and
      (5) Extended ceiling fans.
   iv. Individual bedrooms, bathrooms and other private or unsupervised areas must contain:
      (1) Break-away curtains; and
      (2) Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.

v. Vehicle Safety.
   i. All vehicles used to transport individuals must be maintained in safe driving condition, in accordance with 37 TAC Chapter 23, Subchapter D (relating to Vehicle Inspection Items, Procedures, and Requirements)
   ii. Any vehicle used to transport an individual must have appropriate insurance.
   iii. Every vehicle used for individual transportation must have an easily accessible fully stocked first aid kit and an A:B:C type fire extinguisher.

w. Additional Safety Standards for Children and Adolescents. Respite services providers must adhere to additional safety standards listed in 26 TAC Chapter 748, Subchapter O (relating to Safety and Emergency Practices) and transportation safety standards listed in 26 TAC Chapter 748, Subchapter R, Division 2 (relating to Safety Restraints) when child and adolescent crisis respite services provided in general residential operations.

11. Infection Control

a. Infection Control.
   i. Each facility must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
   ii. The facility must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-related Facilities).

iii. The facility must have written policies for the control of communicable disease in employees and individuals, which includes tuberculosis (TB) screening and provision of a safe and sanitary environment for individuals and employees.

b. TB Reporting Requirement. The facility must maintain evidence of compliance with local and/or state health codes or ordinances regarding employee and individual health status.

i. Individuals. The name of any individual of a facility with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.

(1) All individuals must be screened upon admission and after exposure to TB and provided follow-up as needed.

(2) HHSC will provide TB screening questionnaire for admission screening: https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf

ii. Employees. If employees contract a communicable disease that is transmissible to individuals through food handling or direct individual care, the employee must be excluded from providing these services as long as a period of communicability is present.

(1) The facility must screen and test all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.

(2) All persons who provide services under an outside resource contract must, upon request of the facility, provide evidence of compliance with this requirement.

c. Universal Precautions. Personnel who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.

i. Universal precautions must be used in the care of all individuals.

ii. First Aid Kits must be sufficient for the number of individuals served at the site.

(1) Gloves must be immediately accessible to all staff.

(2) One-way, CPR masks must be immediately available to all staff.

(3) Spill Kits must be immediately accessible to all staff.

iii. Sharps containers must be puncture resistant, leak proof and labeled.

(1) Sharps containers must not be overfilled.

(2) Needles in the sharps containers must not be capped or bent.

iv. Disinfectants and externals must be separated from internals and injectables.

(1) Medications requiring special climatic conditions (e.g. refrigeration, darkness, tight seal, etc.) must be stored properly.

(2) The refrigerator must have a thermometer.

(3) Recorded refrigerator temperatures must be maintained between 36 and 46 degrees Fahrenheit, in accordance with 22 TAC §291.15 (related to Storage of Drugs).

v. Running water or dry-wash disinfectant must be available to staff where sinks are not easily available.

vi. Staff must demonstrate ability to accurately describe the policy for handling a full sharps container.

(1) Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.

(2) Staff must be able to describe the actions to take if exposed to blood or body fluids.

(3) Staff must be able to describe how to clean a blood or body-fluid spill.

(4) Staff must be able to direct QM reviewer to all protective equipment.

vii. Poison Control phone numbers must be posted throughout the facility and information regarding Emergency Medical Treatment for Poisoning must be available to staff.

viii. All medical materials must be properly stored on shelves or in cabinets that must be correctly labeled.

d. Animal Safety. Animals housed at the facility or visiting the facility must be properly vaccinated and supervised.

12. Medication Management

An Emergency Medication Kit should be maintained if the facility contains the staff qualified to handle such medications.

a. Medication Storage. All facilities that provide or store an individual's medication during the length of stay must implement written procedures for medication storage, administration, documentation, controlled substances, inventory, and disposal in accordance with 26 TAC §301.355 (relating to Medication Services). An LMHA must ensure that:

i. Individuals do not retain their personal medications while in the facility;

ii. Individuals receive their personal medications upon discharge from the facility;

iii. Medications that are kept on-site be kept locked at all times; and

iv. Staff are able to provide a copy of the most recent medication stock inspection.

b. Climate Controlled Medications.

i. The facility must maintain a record indicating that staff regularly checks the temperature in the refrigerator.

ii. Refrigerators used to store medications must be kept neat, clean, and free of non-pharmacy and non-medical items. Lab specimens must be stored separately.

c. Labelling Medications.

i. The facility must ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.

ii. Medication labels must not be handwritten or changed.

d. Controlled Substances.

i. Controlled substances must be approved by a physician employed by or contracting or subcontracting with the LMHA or LBHA that operates the facility.

ii. An inventory of controlled substances must include:

(1) Whether the inventory was taken at the beginning or close of business;

(2) Name of controlled of substances;

(3) Each finished form of the substances (e.g. 100mg tablet);

(4) The number of dosage units of each finished form in the commercial container (e.g. 100 tablet bottle);

(5) The number of commercial containers of each finished form (e.g. four 100 tablet bottles); and

(6) Controlled substances must be stored under double locks.

e. Facility Management.

i. The facility management must:

(1) ensure that only licensed medical staff members have access to medications administered to individuals;

(2) maintain a current list in the medication room of all practitioners who are allowed to prescribe medications that are administered from the medication room;

(3) maintain a current list in the medication room of all staff allowed to administer medications to individuals;

(4) maintain a current list in the medication room of all non-licensed, trained staff allowed to observe self-administration of medications; and

(5) ensure that staff does not transfer medications from one container to another. Individuals may independently transfer their own medications from a bottle to a daily medication reminder.

ii. The facility must ensure that staff members have readily available access to a hardcopy or digital format of a medication guide (such as the Physician's Desk Reference or similar publication) in a version that is no more than two years old.

iii. The facility must maintain an Emergency Medication Kit.

(1) The medications in the emergency medication kit must be monitored with a perpetual inventory and make use of breakaway seals.

(2) The medication kit must contain medications and other equipment as specified by the facility medical director. This generally includes, but is not limited to, short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications.

iv. There must be evidence in the clinical records that individuals are educated about their medications whenever medications are prescribed or changed.

v. Child and adolescent crisis respite services provided in general residential operations settings must also adhere to additional child and

adolescent facility medication management standards listed in 26 TAC, Chapter 748, Subchapter L (relating to Medication).

13. Food Preparation and Food Service

When crisis respite services are provided in a private home or in free-standing crisis respite facility of the LMHA or LBHA, the private home or facility is exempt from meeting the Standards as described in Information Item V. Section D. Crisis Respite Services, Subsection 13. Food Preparation and Food Service, a. Inspections.

a. Inspections. If the facility prepares meals in a centralized kitchen on site, it must pass an annual kitchen health inspection as required by the local health department. The facility must:
   i. immediately address any deficiencies found during any health inspection; and
   ii. post the current food service permit from the local health department.
b. Kitchen Standards.
   i. If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the individuals.
   ii. Kitchen or dietary area must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.
   iii. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.
   iv. All facilities must provide a means for washing and sanitizing dishes and cooking utensils must be provided.
   v. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans, cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.
   vi. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.
c. Meal Preparation.
   i. In facilities that prepare meals for individuals, at least three meals or their equivalent must:
      (1) be served daily;
      (2) at regular times; and
      (3) with no more than a 16-hour span between a substantial evening meal and breakfast the following morning.
   ii. In facilities where individuals prepare their own food:
      (1) The facility must ensure that a variety of foods are available for each meal to allow individuals to have a choice of foods to prepare for each meal;
      (2) The facility must ensure that the foods available are nutritious and well balanced, in accordance with the most recent version of the United States

Department of Agriculture's guidelines, and accommodate individual kosher dietary needs or other related dietary practice;

(3) Food must be provided for individuals to prepare at least three meals daily;

(4) The facility must ensure that such items are provided to individuals that require special dietary items; and

(5) Regular food preparation and mealtimes must be established

(6) by the facility.

d. Nutrition and Diets.

i. The facility must provide therapeutic diets when ordered for an individual.

ii. In facilities that prepare food for the individuals, the menus must be prepared to provide a balanced and nutritious diet, in accordance with the most recent version of the United State Department of Agriculture's guidelines and must accommodate individual kosher dietary needs or other related dietary practice.

e. Availability. Food and beverage must be available to accommodate individuals who enter the facility after established meal times.

f. Food Storage. In all facilities, supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period must be maintained on premises. Food subject to spoilage must be dated.

g. Food Service.

i. When meals are provided by a food service, a written contract must require the food service to:

(1) comply with the rules referenced in Information Item V. VI. Crisis Respite Services. 13. Food Preparation and Food Service; and

(2) pass an annual kitchen health inspection as required by law.

ii. The facility must ensure the meals are transported to the facility in temperature-controlled containers to ensure the food remains at the temperature at which it was prepared.

iii. The facility must ensure that at least one facility staff, at minimum, maintains a current food handler's permit.

h. When child and adolescent crisis respite services are provided in a general residential operations environment, crisis respite providers must adhere to:

i. Facility food preparation, storage, and equipment standards listed in 26 TAC §748.3441 (relating to What general requirements apply to food service and preparation?); and

ii. Child nutrition and hydration standards listed in Division 7 of 26 TAC Chapter 748, Subchapter J (relating to Child Care).

VII. Peer Run Crisis Respite Services

A. Definitions

A Peer-Run Crisis Respite (PRCR) program provides short-term, community-based residential crisis respite services to adult individuals ("Guests") who are experiencing, or are at risk of experiencing, a behavioral health crisis but do not require hospitalization or higher levels of behavioral health clinical care. PRCR services are provided in a safe and home-like environment, usually in a house within a residential neighborhood, for a period of a few hours up to several days. PRCR programs provide non-clinical provision of peer specialist services through the evidence-based Peer Support model of care.

PRCRs are operated and staffed by a Peer Specialist Care Team consisting of Certified Peer Specialists (CPS), who use lived experience, in addition to skills learned in formal training, to deliver voluntary, recovery-oriented, person-centered, relationship-focused, and trauma-informed services to promote a Guest's recovery and resiliency. Peer Specialists provide services for an LMHA or LBHA, in accordance with Texas Administrative Code (TAC), Title 1, Chapter 354, Subchapter N (relating to Peer Specialist Services). PRCR program availability varies by region and is dependent on LMHA or LBHA funding. Unlike traditional crisis respite facility programs, utilization of PRCR services are not based on medical necessity determined through clinical assessment.

B. Goals

- Reduce inpatient and law enforcement interventions through crisis stabilization in the least restrictive environment
- Provide an opportunity to address the underlying cause of a crisis before the need for traditional crisis services arises
- Reduce hospitalization by building mutual, trusting relationships between Peer Staff members
- Reduce possible trauma that can occur to individuals during emergency room visits, inpatient psychiatric hospitalizations, and contact with law enforcement
- Provide Guests with critical coping skills to support resilience, recovery and personal growth
- Engage Guests with community resources and support recovery-related outcomes

C. Description

1. Length of Stay

PRCR programs provide short-term hourly or 24-hour care. The average length of stay is 4-5 days, with a maximum length of stay determined by the Guest in coordination with the Peer Specialist Care Team.

2. Admission Criteria

Admission to a PRCR does not require a clinical assessment or enrollment into the LMHA/LBHA utilization management level of care. Each PRCR must develop and implement

admission guidelines that reflect an individualized approach to admission criteria, with acknowledgement that a non-clinical level of care cannot accommodate every individual requesting admission. Admission to a PRCR program must be determined through an intake interview and a collaborative decision made between the potential Guest and the Peer Specialist Care Team.

a. An individual requesting admission must meet the following criteria:
    i. must have a low risk for potential of violence towards self or others;
    ii. must have the ability to independently perform activities of daily living;
    iii. must have the ability to self-administer medications without Peer Staff support;
    iv. must bring no more than a one-month supply of any prescription medication to the PRCR;
    v. may have mild medical conditions that are stable with prescribed and available medications; and
    vi. may have co-occurring psychiatric and substance use disorders (COPSD) resulting in no more than mild impairment.
b. The PRCR must not admit an individual who requires a level of care that cannot be provided through PRCR services. Individuals that require a greater level of care must be referred to a more appropriate service.

3. Egress.

Crisis respite services must be provided in an unlocked facility that provides individual residents restricted entrance and unrestricted exit.

4. PRCR Standards.

A PRCR Program director must:

a. Create a stable and supportive environment with limited supervision provided by trained and competent Peer Staff;
b. Develop and implement operational procedures to assist Guests with obtaining physical and psychiatric medications when they are unable to access these resources independently;
c. Develop and implement operational procedures to provide Guests with immediate access to urgent and emergent non-psychiatric medical assessment and treatment when Guests are unable to access these services independently;

5. PRCR Programming.

PRCRs use self-help strategies, self-determination, and peer-support to address the needs of Guests with the goal of enhancing participation in their life and community. Guest participation is completely voluntary, and all programs and services are elective. The choice of services includes the Guest’s right to choose no services. Guests define and address their own recovery goals and maintain the ability to choose the PRCR Care Team or the professional services that best suit their recovery goals. The PRCR must ensure that programming responds flexibly to the needs of Guests and supports individual and group

participation as fully as possible for Guests with varying physical, psychiatric, intellectual, and sensory processing conditions.

D. Standards

1. Availability

When offered, this service must be available to individuals in crisis 24 hours a day, every day of the year throughout the local service area.

2. Staffing

a. Operational Guidelines.
   i. A psychiatrist must serve as the medical director for all crisis services provided by the contracting LMHA or LBHA. The medical director must approve all PRCR program written policies, procedures, and operational guidelines for subcontracted services provided on behalf of the contractor.
   ii. A psychiatrist must serve as the medical director for all crisis services provided by the contracting LMHA or LBHA. The medical director must approve all PRCR program written policies, procedures, and operational guidelines for subcontracted services provided on behalf of the contractor. While the PRCR's daily operations will be managed by PRCR staff, a medical director needs to be designated for urgent clinical issues ad to review incidents related to quality of care.
   iii. The PRCR Program Director must:
      (1) Ensure that services are provided by staff members who are operating within the scope of their credentialing, job description, and contract specification, in accordance with 1 TAC §354.3055 (Ethical Responsibilities);
      (2) Define competency-based expectations for each PRCR staff positions;
      (3) Ensure each Peer Staff member receives initial training before the staff member assumes responsibilities providing PRCR program services and annually throughout the staff member's employment with the organization.

b. Peer Specialist Certification. The LMHA or LBHA must ensure that CPSs:
   i. complete training and display core competencies for initial certification, and certification renewal, as required by their credentialing entity, in accordance with 1 TAC Chapter 354, Subchapter N, Division 6 (relating to Peer Specialist and Peer Specialist Supervisor Certification); and
   ii. receive documented supervision in accordance with 1 TAC §354.3103 (relating to Supervision of Peer Specialists) and 1 TAC §354.3101 (relating to Requirements).

c. Peer Specialist Training, Competency and Credentialing. The LMHA or LBHA must ensure that Peer Staff members providing Peer Support services adhere to competency and credentialing requirements provided in:

i. Required competencies delineated in 26 TAC §301.331(a)(3)(A) (relating to Competency and Credentialing);
ii. Critical competencies for topics delineated in 26 TAC §301.331(a)(3)(B) (relating to Competency and Credentialing), including: Individual emergency behavior interventions, in 26 TAC Chapter 748, Subchapter N, (relating to Emergency Behavior Interventions) Admission, Service Planning, and Discharge); and
iii. Additional requirements for credentialing as a peer provider, in accordance with 26 TAC §301.331(f) (relating to Additional requirements for credentialing as a peer provider).

d. Peer Staffing Pattern.
i. Trained and competent Peer Staff members must be present and available onsite 24 hours a day, every day of the year.
ii. The PRCR must develop and implement a process for assessing and anticipating Peer Staffing needs.
iii. The PRCR staff must be scheduled in sufficient numbers to ensure individual and staff safety during the provision of needed services.

e. Availability, Duties, and Responsibilities.
i. Duties and responsibilities for all Peer Staff providing Guest services must be:
(1) Defined in writing by the LMHA or LBHA;
(2) Appropriate to Peer Staff training, competency, and experience; and
(3) In conformance with the scope of Peer Staff certification and availability.
ii. Peer Staff members on duty must remain awake and alert at all times.
iii. Peer Staff members must be willing to disclose about personal recovery.
iv. The LMHA or LBHA must develop and implement policies and procedures allowing on-site Peer Staff members to obtain 24-hour access to supervision, consultation, and evaluation as needed from:
(1) A physician (preferably a psychiatrist), a physician's assistant (PA), an advanced practice nurse practitioner (APRN), or a registered nurse (RN) for medical emergencies; and
(2) An RN or Licensed Practitioner of the Healing Arts (LPHA) for clinical emergencies.
v. The PRCR Staff Care Team must consist of a minimum of following:
(1) A Program Director, who supervises the Peer Staff Care Team;
A Peer Services Team Lead, who supervises Peer Navigators and Peer Bridgers;
(2) A Peer Bridger, who provides peer services, such as:
(a) community outreach;
(b) assisting Guests in linkage with community resources; and

(c) gathering Guest satisfaction data after Guests have completed their PRCR program stay; and

(3) A Peer Navigator, who provides peer support and recovery-oriented services, such as:

(a) facilitating peer groups;

(b) mentoring Guests;

(c) teaching psychosocial skills;

(d) modeling hope for recovery;

(e) assisting Guests with navigating through complex social and healthcare systems; and

(f) assists in promoting safety in the living environment.

f. To ensure contractor stays informed and continues receiving updated information, contractor must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization.

3. Intake and Orientation

a. The PRCR intake process is flexible and is based on an informal conversation that focuses on building a relationship with the potential Guest. The Peer Staff member interviews the individual seeking services to form a relationship, explore the individual's current situation and needs, and determines whether the individual may benefit from admission into services.

b. Potential Guests must receive an intake interview from a Certified Peer Specialist Care Team Member prior to admission into services.

c. An individual with capacity to consent must give written consent to receive respite services.

d. Every Guest admitted to services must receive a unit orientation by an appropriately trained Peer Staff no later than 24 hours after admission and in accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities). The orientation must explain the Guest's individual rights both orally, and in writing, in a language and format easily understandable to the Guest. The orientation must include:

i. The rights of Guests receiving treatment;

ii. A description of the PRCR grievance policy;

iii. The schedule of program activities;

iv. A description of the menu of services offered; and

v. Determine that the Guest comprehends the information provided in 1) – 4).

4. Supports and Services

The Peer Staff Care Team provide services by engaging with individuals, demonstrating empathy, trust, and respect. Services are provided in accordance with 1 TAC, Subchapter N, §354.3013 (relating to Services Provided).

a. The LMHA or LBHA must develop and implement written guidelines for intervention and services, which:
    i. are reviewed and approved by the medical director and updated as needed; and
    ii. describe the most effective and least restrictive ways to access appropriate immediate care to stabilize a behavioral health emergency in accordance with 25 TAC Chapter 415, Subchapter F (relating to Interventions in Mental Health Services).
b. The PRCR Program must offer services to include:
    i. Formal Peer Support Services - CPSs use recovery and wellness support, which includes providing information on and support with planning for recovery; mentoring, which includes serving as a role model and providing assistance in finding needed community resources and services; and advocacy, which includes providing support in stressful or urgent situations, and helping to ensure that the recipient's rights are respected, to support Guests and promote possibilities for change;
    ii. Informal Peer Support – Informal, unscheduled groups and informal peer relationships that promote peer to peer self-help opportunities with other Guests;
    iii. Informal Crisis Prevention - Informal individual or group peer support or peer counselor support, education and advocacy, provided to address Guest problems before they escalate;
    iv. Direct Linkages – CPSs refer Guests to outside agencies and community-based services or supports;
    v. Social Inclusion – CPSs coordinate opportunities for socialization and recreational activities that promote the learning of life skills, foster community, and create new support systems; and
    vi. Wellness and Recovery Tools - CPSs provide Guests with opportunities to learn about, develop, and refine personalized tools for managing their mental wellness, using Evidence Based Practices, such as:
        (1) Assisting Guests with wellness and recovery planning through:
            (a) Discovering their own simple, safe wellness tools
            (b) Developing a list of things to do every day to stay as well as possible;
            (c) Identifying upsetting events, early warning signs and signs that things have gotten much worse and, using wellness tools, develop action plans for responding at these times;
            (d) Creating a crisis plan; and
            (e) Creating a post-crisis plan; and
        (2) Declaration for Mental Health Treatment (Advanced Directive) outlining preferred mental health treatment if an individual becomes unable to provide consent.
c. Menu of Services. The PRCR must provide a menu of services to all Guests. The provision of individual and group skills training must be based on the individual

needs and recovery goals of each Guest. Guests maintain the ability to choose the PRCR Care Team or professional services that best suit their recovery goals. Individuals may choose to be provided with peer specialists support and connection to substance use recovery support services. The PRCR must provide programming services that include:

i. Group or individual time including:
   (1) support groups;
   (2) individual time with a peer specialist;
   (3) building social supports;
   (4) trauma-informed peer support; and
   (5) access to mutual understanding and connection; and
ii. Skills training, including:
   (1) training on the creation of a wellness and recovery plan;
   (2) educational activities; and
   (3) learning about recovery; and
iii. Social group activities; and
iv. Recreational activities, which may include:
   (1) art groups,
   (2) exercise groups; and
   (3) cooking and nutrition groups;
v. Unstructured time to explore independent and communal interests;
vi. Activities consistent with the Guest's cultural and spiritual background; and
vii. Other activities supportive to Guests in crisis.

5. Wellness and Recovery Planning

a. The LMHA or LBHA must develop and implement a written guideline and procedures to ensure Peer Staff members:
   i. Provide daily documentation on an individual's progress on recovery goals;
   ii. Document progress on the format approved by PRCR Program Manager; and
   iii. Communicate daily documentation to the Care Team Lead staff member.
b. Linkage to services and continuity of care must be provided for every Guest and include:
   i. Identifying and linking the Guests with all available community-based services necessary to ensure transition to routine care; and
   ii. Providing necessary assistance in accessing those services, including COPSD services, in accordance with 26 TAC §448.906 (relating to Access to Services for Co-Occurring Psychiatric and Substance Use Disorders (COPSD) Clients), and contacting and coordinating with the individual's existing or newly selected service providers in a timely manner and in conformance with applicable confidentiality requirements.
c. A PRCR program must develop and implement written guidelines and procedures to ensure Guests are provided satisfaction surveys to rate the PRCR program and have their grievances addressed.

6. Physical Plant

a. A PRCR physical plant must have written policies and procedures for monitoring environmental safety, in accordance with 26 TAC §301.312 (relating to Environment of Care and Safety).
b. Any new PRCR facility must receive a preoperational, on site Quality Management (QM) review before being open to the public to provide services.
c. All PRCR facilities are subject to HHSC QM reviews. The operating LMHA or LBHA must immediately report to the HHSC Contracts Management department any changes in programming or construction.
d. if the LMHA or LBHA PRCR holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by HHSC, meaning:
    i. Any Quality Management and Compliance reviews will entail only programmatic elements; and
    ii. Any Regulatory Compliance inspection and survey will occur in accordance with assisted living licensing standards located in 26 TAC §301.312 (relating to Environment of Care and Safety).
e. If the LMHA owns and operates a non-licensed facility under an exemption from licensure they are required to register and submit a facility exemption form in conjunction with the Consolidated Local Services Plan submission every two years.
f. A PRCR must provide a clean and safe environment.
g. A PRCR must create a stable and supportive environment.
h. A facility must not be designed to prevent Guest exit and must not use locks, mechanical restraints or other mechanical mechanisms to prevent Guest exit from the facility.

7. Coordination and Continuity of Care

a. A PRCR program must utilize a strengths-based framework that emphasizes physical, psychological, and emotional safety, in accordance with the evidenced-based Peer Support Model.
b. Water/Waste/Trash/Sewage.
    i. Waste water and sewage must be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
    ii. The water supply must be of safe, sanitary quality, suitable for use and adequate in quantity and pressure and must be obtained from a water supply system.
    iii. Waste, trash, and garbage must be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations must not be permitted. The facility must comply with 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).
c. Windows. Operable windows must be insect screened.

d. Pest Control. An ongoing pest control program must be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals must be used.
e. Maintenance and Cleaning.
    i. In kitchens and laundries, peer staff must use procedures to avoid cross-contamination between clean and soiled utensils and linens.
    ii. The facility must be kept free of accumulations of dirt, rubbish, dust, and hazards.
    iii. Floors must be maintained in good condition and cleaned regularly.
    iv. Walls and ceilings must be structurally maintained, repaired, and repainted or cleaned as needed.
    v. Storage areas and cellars must be kept in an organized manner.
    vi. The building must be kept in good repair, and electrical, heating and cooling systems must be maintained in a safe manner.
    vii. A supply of hot and cold water must be provided. Hot water for sanitizing must reach 180 degrees Fahrenheit or manufacturers suggested temperature for chemical sanitizers.
f. Telephone Access. There must be at least one telephone in the facility available to both Peer staff and Guest for use in case of an emergency.
g. Temperature. Cooling and heating must be provided for occupant comfort. Conditioning systems must be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in individual-use areas.
h. Bedroom.
    i. A bedroom must have no more than four beds.
    ii. The facility must provide for each guest a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings.
    iii. Furnishings provided by the facility must be maintained in good repair.
i. Bathroom.
    i. A PRCR must provide At least one water closet, lavatory, and bathing unit must be provided on each sleeping floor accessible to individuals of that floor.
    ii. A PRCR must provide one water closet and one lavatory for each six occupants, or fraction thereof.
    iii. A PRCR must provide one tub or shower for each ten occupants, or fraction thereof.
    iv. Privacy partitions and all curtains must be provided in water closets and bathing units in rooms for multi-individual use.
    v. A PRCR must provide tubs and showers must have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
    vi. A PRCR must provide individual-use hot water for lavatories and bathing units must be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
    vii. A PRCR must provide individuals must have access to towels, soap, and toilet tissue at all times.

j. Storage.
    i. The facility must provide sufficient and appropriate separate storage spaces or areas for the following:
        (1) Administration and Guest records;
        (2) Office supplies;
        (3) Medications and medical supplies (these areas must be locked);
        (4) Poisons and other hazardous materials (these must be kept in a locked area and must be kept separate from all food and medications);
        (5) Food preparation (if the facility prepares food); and
        (6) Equipment supplied by the PRCR for individual needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment etc.
    ii. Storage must not be permitted in the attic spaces.

k. Food storage.
    i. Food storage areas must provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
    ii. Food subject to spoilage must be dated.

l. Laundry. Individual-use laundry, if provided, must utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area must be one-hour fire separated or provided with sprinkler protection.

m. Smoking. The PRCR must develop and implement regulations must be established and if smoking is permitted, outdoor smoking areas may be designated for Guests. Ashtrays of noncombustible material and safe design must be provided in smoking areas. Peer staff must not provide or facilitate individual access to tobacco products.

n. Room Space.
    i. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms must be provided and have appropriate furniture.
    ii. The PRCR must provide dining areas must be provided and have appropriate furnishings.

8. Accessibility

a. The PRCR must comply with the most recent versions of:
    i. the Americans With Disabilities Acts (ADA) Accessibility Guidelines;
    ii. the Texas Accessibility Standards in Texas Government Code Chapter 469, (relating to Elimination of Architectural Barriers); and
    iii. all applicable sections of TAC.

9. Postings

a. The PRCR must post 911 as the emergency contact at, or within view, of the telephone.
b. The PRCR must ensure that designated smoking areas are clearly marked.
c. The PRCR must post a notice that prohibits alcohol, illegal drugs, illegal activities, violence, and weapons, including but not limited to firearms, knives, shanks, brass knuckles, and switchblades on the program site.
d. The PRCR must post an emergency evacuation floor plan.
e. The following must be prominently displayed in areas frequented by individuals:
    i. Contact information for the Rights Protection Officer,
    ii. Contact information, including a toll-free number, and instructions for reporting abuse and neglect; and
    iii. Contact information stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
f. The PRCR postings must be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.

10. Life Safety

a. Life Safety Code. A PRCR must comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code. Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
b. Local Fire Code. A PRCR must be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
c. Code Compliance. A PRCR must maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
d. Emergency Evacuation Plan. The LMHA or LBHA must have in effect, and available to all supervisory personnel, written copies of a plan for the protection of all Guests in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary.
    i. The plan must:
        (1) Include special Peer Staff actions including fire protection procedures needed to ensure the safety of any resident;
        (2) Include special staff actions including fire protection procedures needed to ensure the safety of any individual;
        (3) Be amended or revised when needed;
        (4) Be readily available at all times within the facility; and
        (5) Require documentation that reflects the current evacuation capabilities of the individuals
    ii. All Peer Staff must be periodically instructed and kept informed with respect to their duties and responsibilities under the plan.

iii. The facility must conduct emergency evacuation drills quarterly and calculate evacuation scores in accordance with the fire code under which the facility is inspected.

e. Disaster Plan.

i. The LMHA or LBHA must have in effect and available to all supervisory personnel copies of written protocols and instructions for disasters and other emergencies, per 26 TAC, Chapter 301, Subchapter G, §301.312 (relating to Environment of Care and Safety).

ii. The written disaster plan must address, at a minimum, eight core functions:
(1) Direction and control;
(2) Warning;
(3) Communication;
(4) Sheltering arrangements;
(5) Evacuation;
(6) Transportation;
(7) Health and medical needs; and
(8) Resource management.

iii. The written disaster plan must include processes for identifying and assisting individuals who have mobility limitations, or other special needs, who may require specialized assistance within the respite facility or during facility evacuation.

f. Recorded Inspections.

i. The PRCR facilities must provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections must be signed and dated.

ii. The following initial and annual inspections are required and must be kept on file:
(1) Local Fire safety inspections as outlined in 6.g., below;
(2) Alarm system inspection by the fire marshal or an inspector authorized to install and inspect alarm systems;
(3) Annual kitchen inspection by the local health authority, if applicable;
(4) Fire extinguisher inspection and maintenance by personnel licensed or certified to perform the inspection; and
(5) Liquefied petroleum gas systems inspection by an inspector certified by the Texas Railroad Commission.

g. Fire Safety Inspections.

i. Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal’s Office.

ii. The PRCR is responsible for arranging required inspections and ensuring that inspections are carried out in a timely manner.

iii. The initial and ongoing fire safety reports must be signed by the certified inspector performing the inspection.
iv. These reports must be kept on file and be readily available for review by the HHSC.
v. All fires causing damage to the crisis residential unit or to equipment must be reported to the HHSC Contract Manager within 72 hours. Any fire causing injury or death must be reported to the HHSC Contract Manager immediately. Report must be made by telephone during normal business hours and by telephone call and e-mail during other times, with a follow-up telephone call to the Contract Manager on the first business day following the event.
vi. Open flame heating devices are prohibited. All fuel burning heating devices must be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.

h. Correction Plan. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff must take immediate corrective action to bring the facility into compliance with the applicable code.
i. The facility must have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions.
ii. The facility must have on file documentation by the Certified Fire Inspector that all findings have been corrected and that the facility is in full compliance with all applicable codes.
iii. During the period of corrective action, the facility must take any steps necessary to ensure the health and safety of individuals residing in the facility during the time repairs or corrections are being completed.

i. Newly Operational Facilities. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in Texas. Such certification must be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a crisis residential facility.

j. Pre-operational facility requirements. Any newly constructed or renovated or remodeled unlicensed crisis residential facility must receive a preoperational on-site review by HHSC QM before being open to the public to provide crisis residential services. If the facility has been remodeled or renovated, the inspection by the architect must have been conducted after the remodeling or renovation was completed and before the facility opens to the public to provide services.

k. Evacuation Plan. All facilities must post emergency evacuation floor plans.

l. Individual Safety. The administrator of each facility must ensure that:
i. All Peer staff are oriented and educated about the importance of the use of environmental safety checks in preventing injury or death of an individual;

ii. Systematic environmental safety checks are routinely performed for eliminating environmental factors that could contribute to the attempted suicide, or suicide, of an individual, or harm to a staff member;

iii. Individual bedrooms, bathrooms and other private or unsupervised areas must be free of materials that could be utilized by an individual to attempt, or to die by suicide, or to harm or kill others, such as, but are not limited to:

(1) Ropes;

(2) Cords (including window blind cords);

(3) Sharp objects;

(4) Substances that could be harmful if ingested; and

(5) Extended ceiling fans.

iv. Individual bedrooms, bathrooms and other private or unsupervised areas must contain:

(1) Break-away curtains; and

(2) Breakaway or collapsible rods or bars in wardrobes, lockers, bathrooms, windows, and closets.

m. Vehicle Safety.

i. All vehicles used to transport individuals must be maintained in safe driving condition, in accordance with 37 TAC Chapter 23, Subchapter D (relating to Vehicle Inspection Items, Procedures, and Requirements)

ii. Any vehicle used to transport an individual must have appropriate insurance.

iii. Every vehicle used for individual transportation must have an easily accessible fully stocked first aid kit and an A:B:C type fire extinguisher.

n. Additional Safety Standards for Children and Adolescents. Respite services providers must adhere to additional safety standards listed in 26 TAC Chapter 748, Subchapter O (relating to Safety and Emergency Practices) and transportation safety standards listed in 26 TAC Chapter 748, Subchapter R, Division 2 (relating to Safety Restraints) when child and adolescent crisis respite services provided in general residential operations.

11. Infection Control

a. Infection Control.

i. A PRCR must establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

ii. A PRCR must comply with departmental rules regarding special waste in 25 TAC Chapter 1, Subchapter K (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-related Facilities).

iii. A PRCR must have written policies for the control of communicable disease in employees and individuals, which includes tuberculosis (TB) screening and provision of a safe and sanitary environment for individuals and employees.

b. TB Reporting Requirement. The PRCR must maintain evidence of

compliance with local and/or state health codes or ordinances regarding employee and individual health status.

i. Individuals. The name of any individual of a PRCR program with a reportable disease as specified in 25 TAC Chapter 97, Subchapter A (relating to Control of Communicable Diseases) must be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.

(1) All individuals must be screened upon admission and after exposure to TB and provided follow-up as needed.

(2) HHSC will provide TB screening questionnaire for admission screening: https://www.dshs.texas.gov/idcu/disease/tb/forms/pdfs/TB-810.pdf

ii. Peer Staff. If staff contract a communicable disease that is transmissible to individuals through food handling or direct individual care, the employee must be excluded from providing these services as long as a period of communicability is present.

(1) The PRCR must screen and test all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*.

(2) All persons who provide services under an outside resource contract must, upon request of the PRCR, provide evidence of compliance with this requirement.

c. Universal Precautions. Peer staff who handle, store, process and transport linens must do so in a manner that prevents the spread of infection.

i. Universal precautions must be used in the care of all individuals.

ii. First Aid Kits must be sufficient for the number of Guests served at the PRCR.

(1) Gloves must be immediately accessible to Peer staff.

(2) One-way, CPR masks must be immediately available to all Peer staff.

(3) Spill Kits must be immediately accessible to all Peer staff.

iii. Sharps containers must be puncture resistant, leak proof and labeled.

(1) Sharps containers must not be overfilled.

(2) Needles in the sharps containers must not be capped or bent.

iv. Disinfectants and externals must be separated from internals and injectables.

(1) Medications requiring special climatic conditions (e.g. refrigeration, darkness, tight seal, etc.) must be stored properly.

(2) The refrigerator must have a thermometer.

(3) Recorded refrigerator temperatures must be maintained between 36 and 46 degrees Fahrenheit, in accordance with 22 TAC §291.15 (related to Storage of Drugs).

v. Running water or dry-wash disinfectant must be available to staff where sinks are not easily available.

vi. Peer staff must demonstrate ability to accurately describe the policy for handling a full sharps container.

(1) Particulate masks (surgical masks) must be available to staff and individuals at high risk for exposure to TB.
(2) Peer staff must be able to describe the actions to take if exposed to blood or body fluids.
(3) Peer staff must be able to describe how to clean a blood or body-fluid spill.
(4) Peer staff must be able to direct QM reviewer to all protective equipment.

vii. Poison Control phone numbers must be posted throughout the facility and information regarding Emergency Medical Treatment for Poisoning must be available to staff.

viii. All medical materials must be properly stored on shelves or in cabinets that must be correctly labeled.

d. Animal Safety. Animals housed at the facility or visiting the facility must be properly vaccinated and supervised.

12. Medication Management

It is outside the scope of peer specialist services to provide medication services or to administer prescription or over-the-counter medications. The Program Manager must develop and implement written procedures for Guest medication storage, administration, documentation, controlled substances, inventory, and disposal in accordance with 26 TAC §301.355 (relating to Medication Services).

a. Self-Administration of Medication.
   i. If taking prescription medication(s), the Guest is responsible for taking these as prescribed, without direction or assistance. Individuals may independently transfer their own medications from a bottle to a daily medication reminder.
   ii. The clinical service of medication management is not offered by PRCR Peer Staff, although Peer Staff can assist Guests with accessing Medication assistance in the community by referring Guests to appropriate medical personnel and services. Once an individual is a Guest at the PRCR, any new prescriptions, or refills, brought to the facility must be presented to Peer Staff to document.

b. Medication Storage.
   i. All Guest medications must be securely stored in a double-locked space.
   ii. Medications that require special conditions such as refrigeration, darkness, and tight seal, must be stored appropriately.
   iii. A separate refrigerator must be available to store medications.

c. Climate Controlled Medications.
   i. The PRCR must maintain a record indicating that Peer Staff regularly checks the temperature in the refrigerator.
   ii. Refrigerators used to store medications must be kept neat, clean and free of non-pharmacy and non-medical items.

d. Labelling Medications.

i. A Guest's prescription medication(s) must be contained in a properly labeled, original medication container. The medication container must include a clear and legible label. Labels must contain:
   (1) Name of pharmacy;
   (2) Name of Guest;
   (3) Name of prescribing physician;
   (4) Date prescription was dispensed;
   (5) Instructions for use of medication;
   (6) Name of medication;
   (7) Side effects and adverse reactions to medications;
   (8) Use of psychotropic medication;
   (9) Strength of medication;
   (10) Combination medications without a brand name must list principal active ingredient; and
   (11) Any special handling instructions for medication.

ii. The PRCR must ensure there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.

iii. Medication labels must not be handwritten or changed.

iv. The PRCR must ensure that Peer Staff members have readily available access to a hardcopy or digital format of a medication guide (such as the Physician's Desk Reference (PDR) or similar publication) in a version that is no more than two years old for non-clinical reference purposes only.

e. Controlled Substances. An inventory of controlled substances must include:

i. Whether the inventory was taken at the beginning or close of business;

ii. Name of controlled of substances;

iii. Each finished form of the substances;

iv. The number of dosage units of each finished form in the commercial container;

v. The number of commercial containers of each finished form; and

vi. Controlled substances must be stored under double locks.

13. Food Preparation and Food Services

When crisis respite services are provided in a free-standing facility, the facility is exempt from the requirement to obtain Health Department inspections and certifications.

a. Kitchen Standards.

i. If providing nutrition services, the kitchen or dietary area must meet the general food service needs of the Guests.

ii. Kitchen or dietary area must include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal.

iii. Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary

manner.

iv. All facilities must provide a means for washing and sanitizing dishes and cooking utensils must be provided.

v. The kitchen must contain a multi-compartment pot sink large enough to immerse pots and pans, cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes.

vi. Soiled and clean dish areas must be separated and maintained for drying in a manner that promotes air flow.

vii. All poisonous or hazardous materials such as cleaning supplies will be housed in cabinet separate from those cabinets containing food items

b. Meal Preparation. Peer Staff must not prepare meals for Guests, in accordance with the evidence-based Peer Support model of care.

c. Food Supplies. The PRCR must ensure:

i. a variety of foods are available to allow individuals to have a choice of foods to prepare for each meal;

ii. the foods available are nutritious and well balanced, in accordance with the most recent version of the United States Department of Agriculture's guidelines, and accommodate individual kosher dietary needs or other related dietary practice to the extent possible;
The PRCR must encourage Guests to bring food that is part of each Guests' wellness and recovery plan.

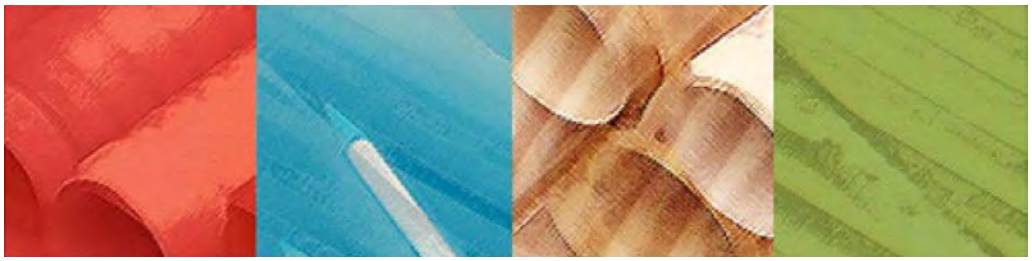
d. Availability. Food and beverage must be available to accommodate Guests who enter the facility after developed meal times.

e. Food Storage.

i. In all facilities, supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period must be maintained on premises. Food subject to spoilage must be dated.

ii. Thermometers will be in all refrigerators to ensure temperature remains at settings recommended by manufacturer.

November 2020



BEHAVIORAL HEALTH DESIGN GUIDE

Formerly:
Design Guide for the Built Environment
of Behavioral Health Facilities

Kimberly N. McMurray, AIA, EDAC, MBA
James M. Hunt, AIA
David M. Sine, DrBE, CSP, ARM, CPHRM

Includes REVISED
Safety Risk Assessment Tool
to align with The Joint Commission's
Recommendations

Behavioral Health Facility Consulting, LLC

Previously Published by:
National Association of Psychiatric Health Systems (NAPHS) 2003-2014
Facility Guidelines Institute (FGI) 2015-2017

Contents

Behavioral Health Design Guide

November, 2020

In an effort to keep up with the rapid increase in the number of products available for use in behavioral health facilities, our website products section will be frequently updated and this document will be updated on an annual basis. The date of each edition is on the cover and at the top of each page of the document.

Readers are urged to check: www.bhfcllc.com whenever referring to this document to assure the latest information is being accessed.

November 2019 Edition

The November 2019 edition was extensively reorganized from the previous editions of 2003 through 2018. The major difference is the inclusion of the "*Baseline Considerations*" section. This is intended to simplify and clarify the differences between the various Levels of Risk introduced in the Safety section discussion. The Section for each risk level addresses how that Level differs from the Baseline Considerations.

This document is intended to represent leading current practices, in the opinion of the authors. It does not represent minimum acceptable conditions or establish a legal "standard of care" that facilities are required to follow.

Introduction

This document is intended to address the built environment of the general adult inpatient behavioral health care unit. Additional considerations that are not addressed here are required for child and adolescent patients, patients with medical care needs, dementia patients, and some patients with diagnoses such as substance abuse and eating disorders.

This document is not a replacement for regulatory requirements, but rather augments them to detail practical means of protecting patients and staff. It is intended to represent leading current practices, in the opinion of the authors. It is not intended to represent minimum acceptable conditions and should not be interpreted as establishing a legal “standard of care” that facilities are required to follow.

Please Note: Product information included in this document is intended for illustration of one or more specific items that are deemed appropriate for use in this type of facility. Comparable products by other manufacturers that meet the same design criteria may be substituted after careful comparison.

A Word from the Authors

This Behavioral Health Design Guide is co-authored by Kimberly N. McMurray, AIA, EDAC, NCARB, MBA, Principal of Behavioral Health Facility Consulting, LLC (BHFC Design); James M. Hunt, AIA, Founder and Retired Senior Consultant of Behavioral Health Facility Consulting; and David M. Sine, DrBE, ARM, CSP, CPHRM, president of SafetyLogic Systems. Kimberly McMurray as practice leader for BHFC Design brings an architectural career dedicated to healthcare design, including a period of being on staff at a major academic medical center. McMurray is currently immersed in the daily contact with Behavioral and Mental Health organizations and designers engaged in the process of navigating through today's complex behavioral health environments.

The writing of the Behavioral Health Design Guide is based on our experiences in the field as operators, designers, consultants, and surveyors. Our goal is to share what we have seen that is working and what we have seen that has not worked. Since the document was first electronically published by the National Association of Psychiatric Health Systems (NAPHS) in 2003 we have received and welcomed countless suggestions, recommendations, and comments from users of the Design Guide, which continue to inform and lead us to new discoveries. We are grateful and humbled by how well our suggestions have been received and that they have inspired others to think of new solutions to the inherent challenges of the mental and behavioral health built environment.

We hope this edition of the Behavioral Health Design Guide (formerly the Design Guide for the Built Environment of Behavioral Health Facilities) will meet the expectations of and prove useful to the operators, clinicians and designers who are entrusted with both the care of behavioral health patients and with the environment of care in which those people are cared for and treated. For this point forward in this document, we will refer to the Behavioral Health Design Guide as simply the "Design Guide".

As always, we introduce this edition with the same reminder we used to introduce the inaugural edition in 2003: "*While a safe environment is critical, no environment of care can be totally safe and free of risk. No built environment—no matter how well designed and constructed—can be relied upon as an absolute preventive measure. Staff awareness of their environment, the latent risks of that environment, and the behavioral characteristics and needs of the patients served in that environment are absolute necessities. We also know that different organizations and different patient populations will require greater or lesser tolerance for risk; an environment for one patient population will not be appropriate for another. Each organization should continually visit and revisit their tolerance for risk and changes in the dynamics of the patient population served.*"

As in earlier editions, we have highlighted products we have found to be more safe and able to withstand the rigors of use in the behavioral health care environment. However, inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product we identify is free of risk. As well, there may be equivalent products available; all facilities should continually look to the marketplace to find products that are safer and more cost-effective.

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This document is intended to represent leading current practices, in the opinion of the authors. It does not represent minimum acceptable conditions or establish a legal "standard of care" that facilities are required to follow.

Resources

***ADA* - Americans with Disabilities Act.** The Americans with Disabilities Act gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications. See www.ada.gov.

***CMS* - Centers for Medicare & Medicaid Services.** CMS is part of the U.S. Department of Health and Human Services and is responsible for the administration of the Medicare and Medicaid programs. They are currently finalizing their proposed "Clarification of Ligature Risk Interpretive Guidelines". Text of the draft is available on their website and at www.bhfcllc.com.

***FGI Guidelines* - FGI Guidelines for Design and Construction of Hospitals.** Published by the Facility Guidelines Institute and is adopted as law by some states and used by some courts as establishing a Standard of Care. Verify edition that may be adopted at any specific location with local Authorities Having Jurisdiction (AHJ). The authors recommend complying with the latest published edition for all projects. This volume includes chapters on free-standing psychiatric hospitals and psychiatric units in general hospitals. Other volumes are available for Outpatient Facilities and Residential Health Care and Support Facilities. For information on purchasing the FGI Guidelines, visit www.fgiguidelines.org.

***HIPAA* - Health Insurance Portability and Accountability Act, 1996.** The Office for Civil Rights in the U.S. Department of Health and Human Services (HHS) enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety. See www.hhs.gov/ocr/privacy.

IAHSS - International Association for Healthcare Security and Safety
They publish security recommendations for many types of facilities, including behavioral health. See www.iahss.org

***NFPA* - National Fire Protection Association.** They publish the NFPA 101: Life Safety Code®, and many other applicable codes and regulations. For more on NFPA or links to new publications, see www.NFPA.org.

***NIC* - National Institute of Corrections.** Some of their standards may be applicable to behavioral health facilities, especially those regarding air grilles. See www.nicic.gov.

***TJC - The Joint Commission*.** There is now free access to a Suicide Prevention Portal on TJC's website. This contains the recommendations of TJC's Expert Panel on Suicide Prevention, related National Patient Safety Goals discussion regarding tools for evaluating the suicidal intention of patients. This is kept updated with the latest information and is available to all without a subscription fee.

More Information on Specific Topics

- **GLAZING: Syroka & Associates, Inc.**
  Bob Syroka, CSI - President (www.syrokaandassociates.com)
- **HOSPITAL SECURITY: Healthcare Security Consultants, Inc.**
  Thomas A. Smith, CHPA, CPP - President (www.healthcaresecurityconsultants.com)

Glossary

- **Ligature-Resistant:** TJC, in its November 2017 Edition of its *Perspectives* newsletter recommends the term "Ligature-Resistant" over "Ligature-Free" because it is not possible to remove all potential ligature risk points that could be used in a suicide attempt. It defines Ligature-Resistant as, "***Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a substantial point of attachment that may result in self-harm or loss of life.***"
- **Tamper-Resistant:** For the purposes of this document, the authors use the term "tamper-resistant" to refer to items that are difficult for patients to remove or damage using items to which they typically have access.
- **Safety Risk Assessment:** The ***FGI Guidelines for the Design and Construction of Hospitals*** (2018 Edition) **Section 1.2-4 Safety Risk Assessment (SRA)** requires that such an assessment, including **Section 1.2-4.6 Behavioral and Mental Health Risk (Psychiatric Patient Injury and Suicide Prevention) Assessment** as described therein be performed for all such facilities.

A Word from BHFC

The ***Behavioral Health Design Guide*** (Design Guide) addresses the built environment for adult inpatient behavioral health care units and the evolving Design Guide was moved from its former home with the Facilities Guidelines Institute or FGI to its present home on the Behavioral Health Facility Consulting, LLC (BHFC) website, www.bhfcllc.com in 2018. We found this move necessary in order to preserve the independence of the Design Guide and, through affiliate relationships, to provide even more organizations and their members access to a document that addresses leading practice design challenges of the built environment for adult inpatient behavioral health care units.

Some of the elements of the Design Guide, such as the **Environmental Safety Risk Assessment tool**, will continue to appear in the FGI Guidelines for Design and Construction of Hospitals and Outpatient Facilities. This Design Guide provides much more detail and leading practices for protecting patients and staff as identified through the authors' years of practice in the field. The Design Guide is not intended as a replacement for regulatory requirements nor to be employed as a legal "standard of care." Its content is provided to augment the fundamental design requirements for behavioral and mental health facilities and to help providers and design teams develop physical environments that support safe and effective behavioral and mental health services.

As always, we should remind readers that the Design Guide does not discuss the additional concerns that must be addressed when designing behavioral health facilities for child and adolescent patients, patients with medical care needs, geriatric patients, or some patients with diagnoses such as substance abuse and eating disorders. These specialty population needs will be addressed in future editions of the Design Guide and the white papers will be posted on our website at www.bhfcllc.com.

The **Appendix** contains information about products that have been found to be more safe for use in the behavioral and mental health built environment but is in no way a complete list of products available that may be appropriate, while recognizing that no product is entirely without risk. We should also point out that the editors vigorously resist offers to monetize the Design Guide or be compensated by enthusiastic vendors.

The Design Guide is updated annually, and while we trust you will find the latest changes helpful, our goal is to provide updates more frequently through the products section on our website; so please return to our website occasionally to make sure you are referring to the most current Design Guide edition and referencing the latest products.

Thank you for your continued interest in and use of the Behavioral Health Design Guide.

Kimberly N, McMurray, AIA, EDAC, NCARB, MBA – Principal

James M. Hunt, AIA – Founder and Retired Senior Consultant

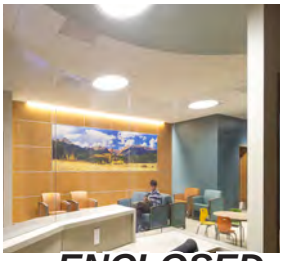
General Comments

A. Space Planning Considerations

Behavioral and mental health units and facilities are preferred to be designed to appear comfortable, attractive, relaxing and as residential in character as possible. The focus on patient and staff safety has often pushed the aesthetics of these units toward the appearance of a prison environment. To better meet the needs of patients, the final design must avoid an "institutional look" while meeting the array of applicable codes and regulations and addressing the therapeutic and safety needs of patients and staff. These no longer need to be either-or trade-offs. Both safety and therapeutic environment are possible in a well-designed facility that has a non-institutional appearance that is correct for the unique conditions that exist in each facility.

1. The ***FGI Guidelines*** Section 1.2-4 requires that a Safety Risk Assessment (SRA) be performed to determine the level of risk that is acceptable for both patients and staff in each part of the patient accessible areas of behavioral health units. The SRA Report is vital and must be consulted in reaching all safety related decisions. Refer to the *Environmental Risk Assessment* methodology, '*Section B*' described in the Design Guide for further discussion and assistance with the development of a SRA.

2. Nurse station designs are preferred to provide the least acceptable barrier between staff and patients. This goal may conflict with staff safety concerns as patients may be able to reach or jump over counters. Some facilities have found ways to design nurse stations that protect against these actions without discouraging conversation and exchange of objects between staff and patients ***(See photos at right, note fine vertical lines in the Enclosed photo)***. When minimal physical barriers are provided, it is often desirable to include a conveniently located lockable door through which staff can retreat when feeling threatened. ***HIPAA*** privacy regulations can make use of an "open" design challenging because patient records, electronic or otherwise, must be protected from view by other patients, visitors, and unauthorized staff. However, advancements in electronic medical records have somewhat reduced the need to locate all charting-related activities and spaces in the area behind the nurse station. Since the electronic "chart" can be accessed from many locations, the area around the nurse station can often be used for more patient-centered activities. When a more open nurse station is achieved, other areas where clinical staff can discuss patients without being overheard is needed.



ENCLOSED

3. Location of gathering areas for patients near the nurse station is encouraged because patients often congregate by the nurse station to socialize. It is far better to plan for this behavior and accommodate it in the original design. Such gathering areas should include comfortable seating and places for conversation, card or board games, and other quiet activities that will not distract staff working in the nurse station. Television

sets and other electronic entertainment equipment is not preferred in these locations. Many facilities are now experiencing issues, especially with younger patient populations, regarding use of personal electronic devices (e.g., iPods, MP-3 players, and similar devices). Patients say these electronics help keep them calm. Wireless earphones are strongly suggested because wires on the earphones can be hazardous.

4. Chart rooms and other staff areas should be located so staff members can have conversations and make phone calls regarding patients and other clinical matters without being overheard by patients or visitors. Teaching hospitals that have a large number of residents and/or students making rounds will need larger spaces for confidential conversations. The expanded use of electronic medical record technology is continuing to change the needs and configurations of these spaces.

5. Facilities for medication distribution should support the organization's practices but allow for flexibility. Medication management has evolved over the years from patients lining up at a window at designated times to staff taking medications to patients wherever they are on the unit. While the trend is strongly toward the latter, some facilities prefer the former or some variation of the two. This practice should be clearly defined in every facility's functional program and safety risk assessment. Flexibility should be designed into the built environment to allow for future changes in how this critical function is provided. Medication rooms and/or zones should also be provided in accordance with the requirements of the ***FGI Guidelines*** and all other applicable codes, standards and regulations.

6. Where possible, locate service areas (such as trash rooms and clean and soiled utility rooms) so they are accessible from both the unit and a service corridor. This eliminates the need for environmental staff servicing these rooms to enter the treatment areas of the unit and possibly disturb patient activities. All doors to these rooms must be kept locked at all times.

7. Traditional nurse call systems for patients to request assistance from nursing staff are not required in behavioral and mental health units by the ***FGI Guidelines***. Significant new developments in duress alarm systems greatly improve safety for staff who find themselves threatened by patients. Sensors located in all patient-accessible areas are activated using a small device that the staff members wear.[650] Staff may activate the alarm when they feel threatened and want other staff to come. Different alarm products annunciate in different ways, but many provide the exact location of the staff member activating the alarm.

8. All electrical outlets in patient rooms are required by the ***FGI Guidelines*** to be tamper-resistant, hospital-grade units on ground-fault interrupted circuits. The breakers for these circuits should be located so staff can easily access them without entering patient rooms. This is easy to accomplish in new construction but can be very difficult to achieve in remodeling projects. If receptacles with individual reset buttons are provided, they should be wired so that activation of one receptacle's breaker does not deactivate the entire circuit.

9. Where possible, locate water shut-off valves for patient accessible bathrooms in corridor walls so they can be accessed from the corridor by opening a locked access door. This

has been successfully accomplished during remodeling projects of existing units, as well as new construction projects.

10. Where possible, locate serviceable parts of patient room HVAC systems where they can be serviced without entering the room. In new construction, consideration may be given to radiant heating and cooling systems that greatly reduce the need for mechanical devices in patient rooms.

11. Housekeeping rooms should be large enough to lock away carts when not in use. All cleaning materials must be locked inside these carts at all times when carts are in patient areas or corridors and not attended by staff.

12. Smoking areas (if provided) should be outdoors. Furniture should be securely anchored in place. Provision should be made for staff observation without having to breathe secondhand smoke. No wastebaskets should be allowed in these areas. Indoor smoking is not permitted in most facilities, and many hospitals now have smoke-free campuses.

13. At the time of this writing, the ***FGI Guidelines*** require patient bedrooms to have a minimum clear floor area of: 1) 100 square feet for single-patient room; and 2) 80 square feet for multiple-patient rooms (Section 2.5-2.2.2.2). FGI indicates the maximum capacity shall be two patients (Section 2.502.2.2.1).

    Recent interpretations by FGI indicate the space under the fixed platform bed should be included within the calculation for clear floor area for behavioral and mental health facilities; based upon the significant differences with the function of the patient room in behavioral health as compared to medical and surgical patient rooms. The behavioral and mental health environment, clinical care generally does not occur inside the patient room. Behavioral and mental health patient bedrooms are designed for safety, sleeping and hygiene.

    All requirements of these ***FGI Guidelines***, the ***NFPA*** 101: Life Safety Code® (2012 Edition), applicable building codes and local AHJs regulations should be reviewed and carefully followed.

14. The concept of "*On-Stage*" and "*Off-Stage*" is widely adopted within medical healthcare facilities and is an emerging consideration for the design of behavioral and mental health facilities, especially in response to the pandemic to limit direct support staff and patient exposures. This concept separates, where possible, patient pathways (on-stage) throughout the facility from materials management food service, clean materials delivery within the facility, as well as staff support areas (off-stage). This separation of support services minimizes noise, disruption, distractions, and patient's exposure to potential elements that if accessed by the patient could be a safety risk – exposing these elements into areas actively used by patients.

15. Technology and Telehealth Resources in mental and behavioral health setting has significantly increased in both inpatient and outpatient facilities enhancing security, communications, safety (both physical and from limiting exposure to airborne viruses)

and patient care. Security enhances for technology include door control, inventory control, facility monitoring and integration of physiological reporting. Health records and multidisciplinary heath team communications include access to continually updated patient records and collaboration by all appropriate members of a patient's interdisciplinary care team; and emerging tele-mental health refers to remote visual/ audio communication between the patient and care team professionals. We are currently working with organizations where auxiliary services such as pharmacy are using telehealth resources to meet with patients rather than in person, even when these resources are physically located on campus.

B. Safety

Safety for both patients and staff is a primary concern for all behavioral and mental health facilities.

The level of concern for how the design of the built environment affects the safety of patients and staff is not the same in all parts of a behavioral health unit or facility. The level of precautions necessary depends on the staff's knowledge of the patient's intentions regarding self-harm and the amount of supervision the patient will have while using that part of the facility. Previous editions of this Design Guide have proposed that the level of concern for patient safety in the behavioral health built environment can be separated into five categories (with five being the highest level of concern). The concept is that areas that patients do not enter can be designed similar to other hospitals. Areas that patients will enter have some latitude in design, construction, and what materials can be allowed. The lowest patient accessible areas are spaces that are behind self-closing, self-locking doors and where staff are always present with patients. Much stricter requirements need to be met for areas where patients will be alone for long periods of time with minimal supervision.

These levels are discussed in detail below and illustrated by Exhibit One ***Environmental Safety Risk Assessment*** matrix. Additional discussion and review of this concept of the five risk level system has been confirmed by independent and peer-reviewed research (Bayramzadeh, S, *Health Environments Research & Design Journal* 2017, Vol.10(2) 66-80). A link to this independent research paper can be accessed through our website at www.bhfcllc.com.

Many organizations have adopted this approach of assessing levels of concern based on a functional statement of intended use and have agreed on the level of risk for rooms or spaces with similar occupant functions. However, caution is necessary as some rooms or room functions can fit comfortably into more than one category or sit on a blurry boundary between two categories. As well, the categories do not always anticipate every use of every room. This blurry boundary can result in clinical staff and facility designers basing design choices on assumptions about the use of a room and its corresponding level of concern that may not meet the actual needs of the stakeholders in an operating environment.

For example, a day room may be located within the sight line of a nurse station that "always has staff present." However, if a patient who can't sleep is in the day room watching television

at 2 a.m. and the only staff member on duty is making rounds, the patient may be “completely alone” for a period of time in a space that may contain hazards.

The authors of the Design Guide propose use of an ***Environmental Safety Risk Assessment*** (ESRA) to facilitate conversation between clinical staff and designers regarding patient and staff safety. The ESRA uses a Cartesian matrix to relate an opportunity for a patient to be alone in a space on one axis to a level of risk of self-harm on the other axis. The greater the opportunity for a patient to be alone, the greater the opportunity for self-harm and the greater the caution that should be taken regarding design choices and materials.

Although patient intent for self-harm is often opaque and difficult to assess, in the matrix we have placed “actively suicidal” on the far end of the scale and describe the opposite end as “self-harm not anticipated.” Privacy ranges from close observation (such as “1:1 observation”) on one end of the opportunity scale and the patient “completely alone” on the opposite end.

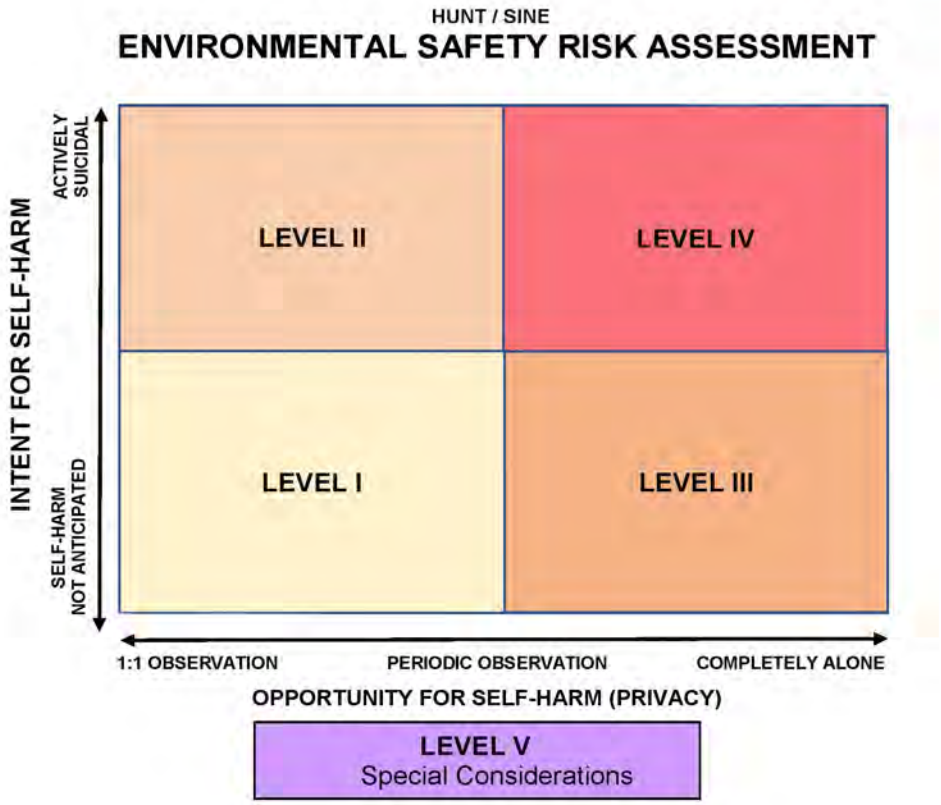
This risk matrix is informed by Veterans Health Administration longitudinal studies that have identified frequent locations of acts of self-harm by inpatients, Joint Commission data, and Richard Prouty’s seminal work on risk maps. Designers and clinicians, rather than seeking agreement on what is meant by the name of a room, may now seek to agree on the actual or anticipated degree of aloneness or privacy a patient will experience in a room or space (independent of its name), and it is that agreement that will drive design choices for the room or space.

For example, a patient bathroom in which the patient is anticipated to be alone and have privacy would be far along the privacy axis. If that assessment intersects far along the patient intent for self-harm axis, the space should be designed with the attributes of a Level IV space as described in this document. In sum, no matter the name of the room, a high level of privacy warrants a high level of concern if it is anticipated that patients who are actively suicidal (or patients with an unknown or unassessed intent for self-harm) are to be treated or housed in that space. While different products may be used for spaces with risk assessments located in the Level IV quadrant of the risk matrix than for spaces in the Level I quadrant, the higher risk locations do not necessarily need to look more “institutional.”

The authors believe the use of a tool such as the environmental safety risk assessment matrix will facilitate necessary conversations regarding patient safety and design between operators, clinicians, and designers. However, the tool is not intended to predict risk levels in a facility, which the authors believe to be dynamic and non-static. Rather, it is intended to encourage dialog and promote a common understanding of the patients designed space is intended for and the risks of that anticipated patient population.

Also note that use of the matrix should not be interpreted as a suggestion that patient privacy is not important or is a risk to be avoided. On the contrary, privacy is generally considered desirable in the behavioral health built environment, although it is associated with a risk that should be considered and mitigated through good design where possible.

EXHIBIT #1 - ENVIRONMENTAL SAFETY RISK ASSESSMENT



***Level I**: Areas where patients are not allowed.*

***Level II:** Areas behind self-closing and self-locking doors where patients are highly supervised and not left alone such as counseling rooms, activity rooms, interview rooms, group rooms as well as corridors that do not contain objects that patients can use for climbing and where staff are regularly present.*

***Level III**: Areas that are not behind self-closing and self-locking doors where patients may spend time with minimal supervision such as lounges, day rooms and corridors where staff are not regularly present. Open nurse stations should be considered under this Level*

***Level IV**: Areas where patients spend a great deal of time alone with minimal or no supervision, such as patient rooms (semi-private and private) and patient toilets.*

***Level V:** Areas where staff interact with newly admitted patients who present potential unknown risks or where patients may be in highly agitated condition. Due to these conditions, these areas fall outside the parameters of the risk map and require special considerations for patient (and staff) safety. Such areas include seclusion rooms and admission rooms.*

Construction and Materials Considerations

Each level of concern in the patient safety risk assessment matrix requires increased attention to the built environment to reduce the potential for patients harming themselves or others. There truly is no "one-size-fits-all" solution to the design of these environments. Many factors must be considered and the patient populations, staffing patterns, organizational culture and challenges of the existing built environment are unique for each unit of each facility. The authors suggest the following baseline set of considerations from which the staff of an organization can begin their considerations of what is the best solution for their facilities. The following suggestions may be adjusted to be either more or less restrictive as desired for individual applications.

A. Baseline considerations for patient areas

For the purposes of this document, the Authors have designated the needs of Level III spaces to be the Baseline for suggested conditions. Some items may be somewhat less stringent for Level II areas if such items are consistent with the Safety Risk Assessment as well as TJC and other regulatory requirements. Some items may need additional attention for Level IV and V areas as discussed in their sections.

Blind spots in corridors and other areas where patients cannot be observed from an attended staff station. All unattended rooms are suggested to be locked at all times to reduce the possibility of patients entering them.

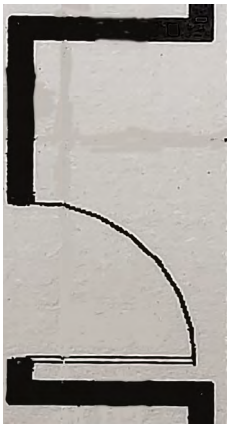
1. Openings

a. Doors:

i. Barricade Risks – The direction of swing is very important. Doors that swing into any room which patients may enter can be susceptible to being barricaded by patients. This can be either intentional or accidental (if a patient should lose consciousness and fall against the door). In either case, it can be very difficult for staff to enter the room when needed. If intentional, it can be to attempt self-harm or to inflict harm on a staff member or another patient. This risk can be mitigated in several ways listed below and illustrated on the next page:

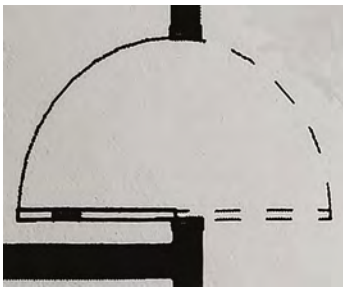
- Out-swinging doors
- Double-acting doors
- Wicket doors (door in a door)
- Unequal pair of double egress doors
- Additional door with out swing

- **Out-swinging Doors** – Doors that are hinged to swing out of the room are more difficult to barricade but may create issues with the Life Safety Code and other building codes by restricting the width of exit passageways. This may be addressed by recessing the door back from the face of a corridor wall which may create an alcove that is difficult to observe. **The *FGI Guidelines* warn that alcoves are to be avoided** *(FGI 2.5-1.5.1.1)***.**



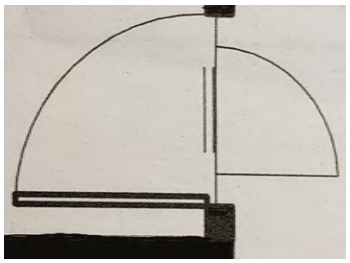
Out Swing Alcove

- **Double-Acting Doors** – doors that are hinged to normally swing into a space, but staff may release to swing out of the space is one option to the barricading risk. The hardware needed for this solution is discussed below in the Door Hardware section.



In Swing - Dbl Act'g

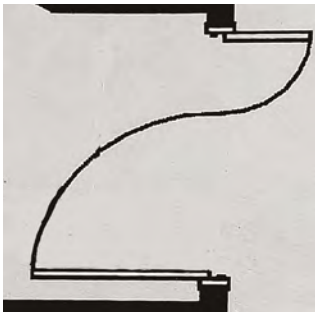
- **Wicket Doors** – These are single in-swinging doors that have a portion of the door that is locked in the closed position and is hinged to swing out of the room. This can allow access to the room if barricading occurs.



In Swing - Wicket

- **Unequal Pair of Double Egress Doors** – If there is sufficient length of corridor wall present inside the room, a pair of doors can be provided. The active leaf is normal width and for normal use and is hinged to swing into the room. The inactive leaf is narrower and hinged to swing out of the room when unlocked by staff for emergency access. These can be done with or without a vertical frame member (mullion) between the two doors. Providing the mullion allows less complicated hardware and quieter operation. Not providing the vertical frame member results in additional opening width that is sometimes desirable.

- **An Additional Door** can be provided (preferably out-swinging) that can be used by staff to leave the room or for other staff to enter the room. This can be an effective safety measure. The additional door may be into an adjacent room such as an office if the door is not needed for code compliance reasons. All "additional doors" provided for this purpose will need to be barricade resistant and meet all applicable codes and regulations.



Unequal Pair

ii. Door Materials – Doors in behavioral health facilities are subject to heavy use and possibly extensive abuse. They make up a significant percentage of the exposed wall surface in corridors and thus have a strong visual impact on these spaces.

- Painted steel doors are durable, easily touched up or refinished, but more institutional in appearance. Doors with wood veneer faces and stain and varnish finish are more "residential" in character but are easily damaged and difficult to repair. Plastic laminate is easily chipped and may yield sharp objects that may be used as weapons and is never advised in these facilities. If existing doors have plastic laminate for exposed surfaces it may be desirable to provide stainless steel kick plates, door edges, and other add-on devices, although these can add to an institutional look. (NOTE: The installation of kick plates may invalidate the fire rating of doors in some jurisdictions.) Kick plates and other protective devices are also available in durable synthetic materials that come in a variety of colors, which soften the stainless-steel look but can still result in a patchwork appearance.


#25a

- Durable Synthetic Facing - A possible solution to these issues is doors faced with a durable synthetic that has a wood grain appearance. Some of these doors have removable end caps,[25a] which can be replaced if they become damaged at much less expense than replacing the entire door. Doors with synthetic faces without the replaceable end caps[25b] are available for a lower initial cost.

  Although the first cost for these synthetic-faced doors is higher than for doors of other materials, they do not require the added expense of finishing the doors and purchasing and installing kick plates, etc. Thus, the life cycle cost can potentially be less than for other doors, and the appearance over time may be a significant improvement.


#25b

b. Door Hardware – Hardware on doors that connect to a higher Level of Risk shall have hardware suitable for the higher level of risk.

i. **Double-Acting Continuous Hinges**[113] are preferred and can be used on patient room-to-corridor doors to counteract barricading without the hazard presented by pivot hinges. These continuous hinges can be paired with full-height emergency stops[115] that lock in place and can be easily unlocked to allow the door to swing into the corridor.

ii. **Geared-Type Single -Acting Continuous Hinges**[111] are a solution for retrofit frame conditions at doors patients will pass through and normally locked doors that have hinges exposed in patient accessible areas because they minimize possible attachment points. These hinges are available from various manufacturers with a “hospital tip” (factory installed closed-sloped top) and continuous gears that resist ligature attachment.[111] Field cutting the top of hinges to create this slope is strongly discouraged because that often exposes voids that may be used as ligature attachment points.

Geared continuous hinges do provide significant pinch points between the two leaves of the hinge when the door is closed. If this is not an acceptable risk to an organization, double acting continuous hinges that do not have this pinch point[113] can be provided.

iii. **Wicket Doors**[44] use single acting continuous hinges with hospital tips for the main door and the center portion is mounted on a continuous hinge with hospital tip (or concealed) hinge and secured with a deadbolt lock that has no visible hardware on the room side of the door. Care should be taken with the detail of the edge of the smaller panel so that a crack is not provided that can be seen through and is smoke tight if required.

iv. **Unequal Pair of Double Egress Doors** - both doors may be mounted on single acting continuous geared hinges with hospital tips. The lock-set can be the same as any other single-acting door. If the mullion is not provided, a deadlock with concealed bolts that engage the head of the door frame (and possibly the floor) is needed for the smaller inactive leaf. This deadlock is similar to item #143b except that it is preferred to not

have any visible hardware on the room side of the door. If the mullion is provided, a deadbolt that does not have any exposed hardware on the inside can be used to secure the door into the mullion

v. **Closers** – See Level II

vi. **Lock-sets** – Use of some type of ligature-resistant lock-set is recommended for all door handles in patient-accessible areas. A lock-set handle can be used for ligature attachment in three ways: pulling down, pulling up and over the top of the door, and tying something around the latch edge of the door using both the inside and outside handles (transverse). The latchbolt itself has even been used successfully as an attachment point and some companies offer a tapered bolt to help with this. The downside to the tapered bolt is that it makes it easier to open a locked door by using a small piece of cardboard or other item. Also, the opening behind the strike plate can be a ligature attachment point; for this reason, a box should always be provided behind the strike plate. In our opinion, the perfect solution for this dilemma does not exist at this time. Several of the better options are discussed below.

- Lock-sets with a Lever Handle[130] – These effectively reduce the level of risk of up and down pressure but are susceptible to transverse attachment. The lever should move freely in both directions when locked to reduce ligature attachment risks. This type of handle is more typical (less institutional) in appearance and operation than other choices. Both of these qualities are very desirable in items that patients will touch and use on a regular basis. However, lever handles may be susceptible to transverse attachment as mentioned above.

- Crescent Handle Lockset[136] – This type of lock-set has a lever handle and thumb turn that are ligature-resistant and may meet ADA requirements. It is available with a handle that can be mounted in either horizontal or vertical position and allows the user's hand to easily slip off the free end.

- Push/Pull Hardware – This type of door handle is available with a flush push pad on one side and a ligature-resistant pull handle on the other.[137b]

- Modified Lever Handles[131] – These provide minimal ligature attachment risk but have an unusual appearance and operating motion. They are available in various designs.

#131a

i. **Elopement Buffers** (generally called sally ports) – The 2018 Edition of the ***FGI Guidelines*** calls for the "*primary access point to the locked unit to be through a sally port*" (Section 2.5-2.2.1.2). The Appendix for this section states that a sally port has two doors (or two sets of cross-corridor doors) that are electrically interlocked[144] and "the sally port should be long enough and the door wide enough to accommodate passage of a bed or laundry cart."

#131c

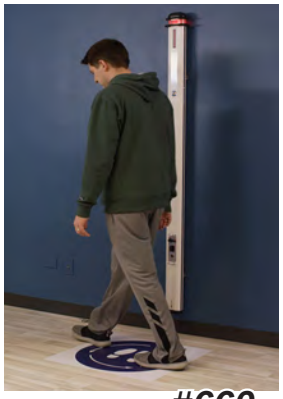
ii. **Access Control of Elopement Buffers** (sally ports) and other entry/exit points from a locked unit, including stairways.

The Safety Risk Assessment should state whether normally locked unit exit doors are going to automatically unlock when the fire alarm is activated (fail safe operation) or remain locked when the fire alarm is activated (fail secure operation). This determination should be reviewed with the local code authority for compliance with local regulations.

- Provide intercom (or telephone) for communication to staff stations from outside the unit if needed.

- Electronically controlled access systems are preferred for sally ports. These may be operated by a switch at the nurse station if the door is clearly visible from the location of the release button. (Care should be taken to assure that patients are not in the area when the door is released.) Card readers or keypads adjacent to the door are also commonly used. These are readily available from hardware suppliers and are often extensions of systems already in place at the facility.

- Metal Detectors[660] – Some organizations have expressed the desire to use metal detectors to assist with screening patients and/or visitors entering their behavioral health facilities. Some choose to use hand-held detectors and others use standard walk-



#660

through detectors. These are addressed under Section #10 Electronic Safety.

iii. **Cross-Corridor Doors** – These doors are provided for several reasons, and each has its own unique function and requirements. Some are part of code required fire rated partitions and normally held open and others are to restrict patient or public access and normally locked and may automatically unlock when the fire alarm is activated (fail safe operation) or remain locked when the fire alarm is activated (fail secure operation).

- When there is concern that electromagnetic locks may not be sufficient to hold these doors when impacted by patients, concealed deadbolts with the electric release in the lever handle[109] (or card reader) or electric strikes (for single doors) may be provided. Electronically controlled access systems are preferred.

- Door closers may be required or desired for these doors depending on their purpose and function. Doors that will be held in the open position will probably have an exposed arm that should be acknowledged in the Safety Risk Assessment as a known risk that the staff needs to be aware of.

- Magnetic hold-open[101] devices where required or desired for doors that are to be normally open and must close when the fire alarm is activated and are suggested to be as discussed below.

- Hinges for these doors are preferred to be continuous geared hinges with hospital tips. Pivot hinges are discouraged because the top pin is presents a serious ligature attachment risk.

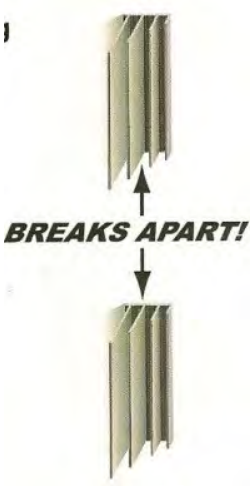
iv. **Hardware for other unit doors**

- Doors for which applicable codes and regulations require a closer but that need to be open to allow staff observation of patients are preferred to be provided with a closer that has a built-in release[101] that allows the door to close automatically when the fire alarm is activated. The more standard magnetic hold open devices that are separate items provide ligature attachment risks and are less desirable.

#101

- Doors that swing into rooms that patients will enter, are strongly suggested to have one of the barricade-resistant methods discussed above.

v. Door Smoke Seals – These may be required in some situations and are often applied with adhesive strips that can allow patients to remove them to use as ligatures. Smoke seals that break into 8"- long pieces[10] are preferred for use on all doors that patients will pass through. These are available from several manufacturers.



#10a

vi. Door Hardware for patient use toilet and shower room doors that open into patient accessible areas other than patient bedrooms are suggested to have the following:

- Full-size, tight-fitting doors
- Out-swinging geared continuous hinges with hospital tips or double acting hinges with emergency release stops
- Ligature resistant handles and storeroom function locks
- Closers that are either concealed or not mounted on the toilet or shower room side of the door.
- Over door alarms


#150a

vii. Over Door Alarms - The top of all tight-fitting doors provides a pinch point that allows a patient to tie a knot (in a sheet, the leg of a pair of jeans, or other object), place it over the top of the door, and close the door to create a hanging device. One way to reduce this risk is with a pressure-sensitive or photoelectric device placed near the top of the door that will sound an alarm[150] when activated. The door bottom can also present a risk if the "*gator roll*" technique is attempted. One product will detect this also.

c. Windows - When glazing that is exposed in patient-accessible areas is broken it needs to stay in the frame and not yield sharp shards that patients could use as weapons. Terminology can be confusing in that laminated glass like that used in vehicle windows is often referred to as "safety glass" but, when broken, can yield large sharp pieces. All

glazing materials that are exposed in all patient accessible areas should be considered, including the exterior surface of windows accessible from exterior courtyards to be used by patients.

The 2018 edition of the ***FGI Guidelines*** contains the following reference to window testing:

2.5-7.2.2.5 Windows...

(1) Windows located in patient care areas or areas used by patients, including the exterior pane of windows accessible by patients for outdoor courtyards, shall be designed to limit the opportunities for patients to seriously harm themselves by breaking the windows and using pieces of the broken glazing material to inflict harm to themselves or others.

(a) All glazing (both interior and exterior), borrowed lights, and glass mirrors shall be fabricated with polycarbonate or laminate on the inside of the glazing or with any glazing that meets or exceeds the requirements for Class 1.4 per ASTM F1233: Standard Test Method for Security Glazing Material and Systems.

(b) Use of tempered glass for borrowed lights shall be permitted.

(2) To prevent opportunities for suicide, self-harm, and escape, the entire window system and the anchorage for windows and window assemblies, including frames and glazing, shall be:

(a) Designed to resist impact loads of 2,000 foot-pounds applied from the inside

(b) Tested in accordance with AAMA 501.8-13: Standard Test Method for Determination of Resistance to Human Impact of Window Systems Intended for Use in Psychiatric Applications. Where operable windows are used, hinges and locking devices shall also be tested.

Advances in different types of safety glass (see “Glazing” below in this section) make it worthwhile to consult an expert for advice for a specific project.

i. **Exterior Windows** – The height above the ground, patient population, and many other factors should be taken into account in choosing these materials. Comply with the ***FGI Guidelines*** and all applicable codes and regulations for glazing, frame installation and operable sash.

   In locations where the building’s prime window does not meet the requirements of the ***FGI Guidelines***, an additional layer is sometimes provided inside of the prime window to provide the required protections.

ii. **Interior Windows -** These do not have the same concerns of falling from heights as exterior windows, but breakage concerns are similar. Careful attention should

be paid to fire-rated partitions and all applicable building and fire code regulations as well as the ***FGI Guidelines***' requirements listed above.

Some facilities prefer to use painted hollow metal window frames for these windows because they have rounded corners and aluminum frames often have very sharp corners.

#61b

d. Operable Windows – Windows in all patient-accessible areas should comply with all applicable codes and regulations for operable sash. Where operable windows are provided, they should be equipped with sash control devices that limit the opening to 4 inches per the ADA 4" ball test and that, where required, can be released to full opening using a key for evacuation purposes. Window systems are also available that allow fresh air[61] through a vent at the bottom or by sliding the window open a few inches.

e. Glazing - (Interior and Exterior) –

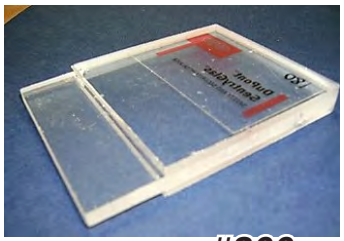
i. Standards – All glazing in patient-accessible areas should be security glazing as discussed in the ***FGI Guidelines***' subparagraph "c" above.

ii. Impact-Resistant Glass Products – Several glass manufacturers[200] offer products that may be appropriate for use in behavioral health facilities. The products chosen will vary depending on the size of the opening, type of frame, patient population being served, and location of the glazing in the unit (as determined by the patient safety risk assessment) including the distance the opening is above grade. We suggest contacting manufacturers directly to determine which products may be appropriate for a specific project.

#205a

- Fire-Rated Glass[205] – Clear fire-rated glass products are now available in a variety of types and ratings and some are rated for impact resistance.

- Glass-Clad Polycarbonate Glazing[200] – Two layers of heat-strengthened glass are bonded to a polycarbonate core. This combination keeps the broken material in the frame and reduces patient access to shards of glass that could be used as weapons and is usually available in 7/16" and 9/16" thicknesses. This type of product has been known to

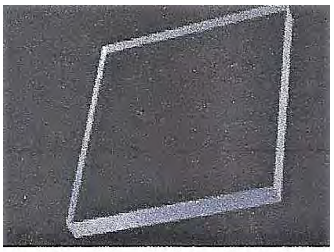


#200a

be available for lower cost than polycarbonate glazing for some projects.

- Heat-Strengthened Glass – Although more difficult to break than regular float glass, heat-strengthened glass has about half the strength of tempered glass. Heat-strengthened glass may be a good choice if it is laminated and high-impact resistance is not required for the location.

- Polycarbonate[201] (Lexan) – Polycarbonate panels are highly impact-resistant and available in a variety of thicknesses from several manufacturers. These products will deflect upon significant impact near the center of large panels that can result in large pieces coming out of their frames. Care should be taken to assure that the depth of the stop securing the panel will be able to hold it when subjected to this and other impacts. This material is also highly susceptible to scratching and is a frequent target of patients who write profanity and draw pictures. Mar-resistant coatings are available, but they do not eliminate this concern. Recent projects have indicated this may be the more expensive than glass-clad polycarbonate products.



#201a

- Security Film – If replacing existing glass is cost-prohibitive, applying a window film security laminate[190] to existing glass may be an alternative. Although these films are susceptible to scratching and defacement by patients, they may be removed and replaced at less cost than replacing glass or polycarbonate panels. The manufacturer's installation instructions should always be carefully followed including any impact-protection adhesives and a perimeter attachment system needed to hold the glass in the frame if broken. In our opinion, claims that these window films will prevent glass from breaking should not be relied upon.

- Tempered Glass – This may be acceptable for use in some patient-accessible areas such as small windows in doors, portions of glass walls separating activity rooms from corridors, and patient toilet room mirrors. Tempered glass is more impact-resistant

than float glass or laminated glass but will break into many small pieces and fall out of the frame, which may allow a patient to elope. As well, each piece may have sharp edges. Patients have been known to break tempered glass mirrors and rub the inside of their wrists on the broken surface to cut themselves or swallow the small pieces of glass. This hazard may be reduced by covering the tempered glass with a security film as described above.

#200

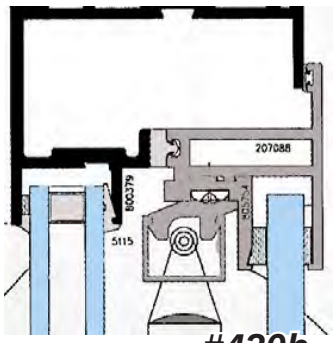
- Laminated/Heat Strengthened Glass[200] - Two layers of heat-strengthened glass bonded to a Sentry Glass Plus (SGP) interlayer, which helps the glass stay in the frame when broken.

#205b

- Wire Glass – Standard wire glass will break and yield sharp shards of glass and is generally not permitted by many current codes and regulations. There are new wire glass[205b] products that are rated for both security and fire by their manufacturers that may be considered. Verification with local AHJ is always recommended before purchasing new products.

f. Window Coverings –

i. **Mini-Blinds** – Mini-blinds mounted behind safety glass[200] are preferred because the blinds are not accessible to patients. Care should be taken to assure that any exposed devices for controlling the tilt of the blinds do not create a potential ligature attachment point. Some commercially available window assemblies have all these features.[430] Exposed mini-blinds are discouraged because they provide access to long cords, wands and slats.



#430b

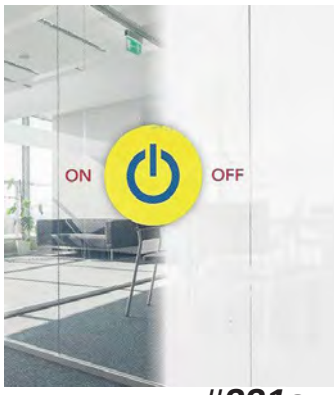
ii. **Roller Shades**[440] – Roller shades specifically manufactured for use in psychiatric hospitals are another option.

These have enclosed security roller boxes, security fasteners, cordless operation, and locking devices that resist tampering by patients may be acceptable for some patient populations. If access to these blinds by patients is deemed not acceptable by the Safety Risk Assessment, electrically operated standard roller blinds may be installed behind security glazing.

#440a

iii. **Electrically Obscured Glazing** [221] is becoming more reasonably priced and is an option for controlling privacy as long as the glazing material meets the requirements of the ***FGI Guidelines*** for glazing in patient areas.

iv. **Curtains and Curtain Tracks** – Curtains and associated tracks of any type (including those designated as "breakaway" and represented by their manufacturers as "safe for psychiatric hospitals") are NOT recommended for use in any patient-accessible areas, especially patient rooms and patient showers.



#221a

2. Finishes

a. Gypsum Board – Abrasion-resistant and impact-resistant gypsum board[230, 231] hung on 20-gauge or heavier metal studs spaced no more than16 inches on center is typically considered minimum construction for these areas. Sound-deadening gypsum board[232] is available to help reduce noise levels from traditional hard surfaces. Consult manufacturers regarding the characteristics of the material determined most appropriate for a particular installation. These products are available from several manufacturers.

A painted finish is preferred because it is easy to repair and the cost of renewing or changing colors to keep up with current trends is relatively low. Also, painted finishes help create a residential or home-like ambiance while still meeting institutional requirements.

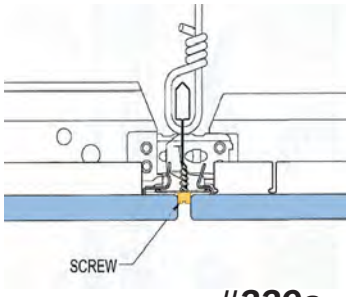
b. Ceilings – Ceiling heights lower than nine-foot-high are discouraged because it is easy for patients to reach them and tamper with the ceilings and ceiling-mounted devices. Ceiling heights of nine feet and above are not immune from tampering and must be evaluated in the Safety Risk Assessment for each area of each unit.

i. **Tamper-Resistant Ceilings** are preferred for all areas of a behavioral health facility. If sound attenuation for gypsum board ceilings is desired, sound absorbing gypsum board[232] may be used or 1'x1' acoustic tile can be adhered to the gypsum board.

ii. **Access** - Where accessibility to mechanical, electrical, and communication equipment is needed, The Joint Commission's November 2017 Edition of Perspectives

(modified by subsequent FAQ's also published in later editions of Perspectives) currently allows unsecured lay-in ceiling to be used under certain circumstances. As of this writing, the authors are not aware of any manufacturer who produces hold-down-clips that are specifically recommended for use to limit patient access above the ceiling. Systems relying on hold-down clips always result in the last tile being placed not being secured unless some form of locked access panel is provided to allow installation of the clip on the last tile.

iii. **Existing Ceiling Grid System** - There are several tamper-resistant solutions that can reuse the existing ceiling grid system and may be less expensive than typical gypsum board ceiling installation that may be considered:



#239a

- Remove existing ceiling tile and install specialty 2'x2' metal ceiling panels[239] with tamper-resistant screws in the recessed joints to resist removal. This system will allow access at any point and is available in sound absorbing models.

#234a

- Remove existing ceiling tile and install special clips[234] that are made to fit over existing grid members that are at least intermediate grade steel system (not aluminum). Then attach 5/8" thick sound absorbing gypsum board ceiling (mud and tape joints – paint) to these clips. Lockable access panels will be required at all necessary locations. It may be necessary to support light fixtures, etc. independently of the existing grid to avoid overloading the carrying capacity of the existing grid.

b. Wall Base – Use of thin, flexible rubber or vinyl baseboards that are applied only with adhesive and are intended to cover the joint between the wall and floor is strongly discouraged. These become prime targets for patient tampering and can be used to conceal contraband.

There are several alternative choices for base material and installation that may offer less risk:

i. **Seamless epoxy flooring**[250] that has an integral coved base is an option as long as there is no metal or plastic edge strip on the top of the base.

#250c

ii. **A premolded base**[240] that extends onto the floor plane, finishes flush with the top of the floor tile, and is heat-welded to the flooring may be acceptable in some locations. However, use of this product does not address the issue of hiding contraband unless the top edge is sealed with a pick-resistant sealant.[20]

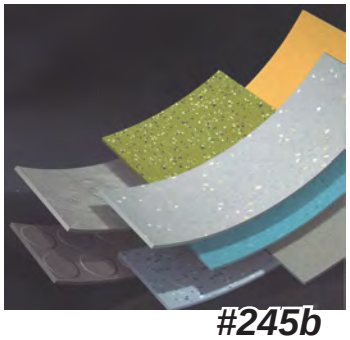
#240

iii. **Wall and Floor** A thick rubber base that resembles wood base profiles [241] is available and provides a more "residential" appearance. All joints to the and all vertical joints should be sealed with a pick-resistant sealant.[20]

iv. **Wood Base** - in some cases, a wood base with a minimum ¾" thickness that is adhered to the wall, secured with countersunk tamper-resistant fasteners, and sealed with pick-resistant sealant[20] has been used successfully. If desired, this can be given a semi-transparent stain finish to provide more of a residential look.

#241a

b. Flooring – Carpet[255] or sheet vinyl[245] meeting class A rating should be used. Avoid patterns and color combinations that may appear to "animate", abrupt contrasting color changes that could appear as objects that need to be stepped over or other visual misperceptions by patients. Anti-microbial sheet carpet (formerly called "broadloom") with solution-dyed yarn and moisture-resistant backing[255] is effective in reducing ambient noise and generally works well in these facilities. This is available from most major carpet companies. Sheet vinyl[245] or other hard surface material is preferred where wet or potentially messy activities will be conducted.



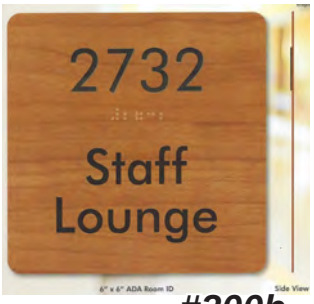
#245b

c. Abrasion Resistant Coatings[280] – Any areas where excessive wear is anticipated, such as corridors and seclusion rooms without wall padding may be coated with paint materials that have more resistance to abrasion and possible abuse.

3. Specialties

a. Signage – Room Signs[300]

i. **Flexible Room Signs** are available that are applied with adhesive and will not provide a weapon to patients



#300b

if removed. These can include braille lettering and meet ADA requirements.

ii. **Rigid room signs**[300d] that are installed with multiple tamper-resistant screws are more difficult to remove and also can include braille lettering to meet ADA requirements.

#300d

b. Corridor Handrails – may not be required in behavioral health units but may be indicated as needed by the Safety Risk Assessment because of needs of the patient population being served having equilibrium issues due to medication side effects or other reasons. If these are provided, there is a choice between leaving the anchors for the rail exposed (which creates ligature attachment point opportunities) and providing a solid filler between the rail and the wall (which helps reduce ligature attachment points and creates a place for trash to collect and can be an infection control cleaning problem). The "correct" answer for any given section of railing will depend on the facility's Safety Risk Assessment and the amount of observation of the specific location.


#330a

c. Wall Protection – Large sheets of durable wall protection material are available in solid color finish or with a wide variety of printed artwork.[320] However, the standard vinyl trim pieces that come with this material are <u>not</u> recommended for use in behavioral health applications. Rather, the edges of the material are suggested to be tightly fitted together and sealed with pick-resistant caulk.[20]

#320

d. Toilet Accessories – See Level IVb

e. Mirrors and Domes:

i. **Mirrors** - Glass-laminated polycarbonate mirrors in ligature resistant wood frames[360] offer an option with a residential appearance and are scratch resistant. (See also Level IVb-3f for toilet room mirrors)


#360a

ii. **Observation Dome Mirrors** – Convex mirrors installed in corridors, seclusion rooms, and other patient-accessible locations to assist with observation of patients are preferred to be made of a polycarbonate that is a minimum of 1/4" thick, filled with high-density foam, and have a heavy metal frame that fits tightly to the wall and ceiling.[420] Convex mirrors made of polished steel are also available. The perimeter of the mirror is recommended to be sealed with pick-resistant caulking.[20]


#420a

f. Pick-Resistant Caulk – Pick-resistant caulking[20] is strongly suggested for all joints between objects and surfaces that do not fit tightly and may provide opportunities for patients to hide contraband, attach ligatures or grip items to remove them. It is preferred that this material not set up hard (like epoxy) but remain pliable and be able to move with its substrate over time. Verify compatibility with all adjacent materials before application.

#20b

g. Paper Trash Receptacle Liners - Coated paper liners[1] are strongly suggested for all trash receptacles to which patients have access including large receptacles in dining and activity spaces. Paper liners with rope handles may present ligature risks. Plastic liners should be prohibited because of the risk of suffocation.

#1

h. Kitchen Equipment Considerations - (Levels II and III only)

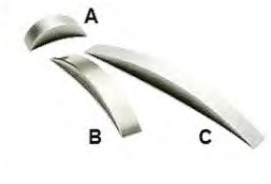
4. Furnishings

a. Built-in Cabinets - (securely anchored in place)

i. Cabinet Doors -

- All cabinets that contain items that patients are not to have access at all times they are present in the space are strongly suggested to have lockable doors.

- Cabinets that contain items that patients are allowed to access at all times they are in the space are strongly suggested to not have doors and to have shelves that are securely fixed in position to resist both upward and downward pressure. Adjustable shelves are discouraged because they are easily removable and may be used as weapons.



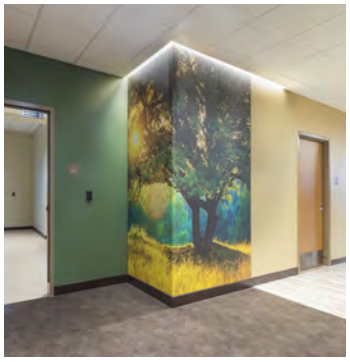
#460a

ii. Cabinet Pulls – These are suggested to be recessed, with no protruding openings, or of a closed ligature-resistant type.[460]

iii. Cabinet Locks – These are very important in all patient-accessible areas. Cabinets used to store items that patients could use to harm themselves or others should be kept locked at all times when patients are present. This can lead to staff constantly looking for

#465a

the right key on a large key chain. One solution is to provide locks that can be unlocked with a key that staff already carry, such as the key used to activate the fire alarm. Another solution is to use existing key access cards or a pushbutton keypad.[465] These are becoming more affordable and should be particularly helpful in examination/treatment rooms and any locked cabinets in patient rooms.



b. Decorative Crafts - Pictures and Artwork – All pictures and artwork in patient-accessible areas must be given special consideration:

i. Murals – These can brighten and add interest to corridors and day rooms and have been used very effectively in some facilities. It is usually a good idea to cover them with at least two coats of a clear sealer for protection, but patients typically enjoy these and defacing them is not usually a problem. Murals are also available on wall vinyl and wall protection materials.

#320b

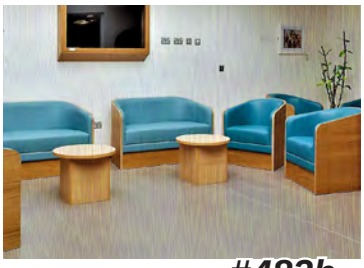
ii. Wall Protection – Large sheets of durable wall protection material are available with a wide variety of printed artwork.[320] However, the standard vinyl trim pieces that often come with this material is not recommended for use in behavioral health applications. Rather, the edges of the material could be tightly fitted together and sealed with pick-resistant caulk.[20]

#476b

iii. Frames – Specially designed frames[476] that slope away from the wall and have polycarbonate[201] glazing are recommended. The frames that are screwed to the walls with a minimum of one tamper-resistant screw[470] per side are preferred to provide a tight fit to walls which may have uneven surfaces. The joint at the top is suggested be sealed with a pick-resistant sealant.[20] Some of these frames allow for easy replacement of the images and provide the opportunity for patients to customize the displays with personal photos, etc.

iv. Printed Flexible Vinyl – Another option is to print artwork on flexible vinyl[301] that can be attached to walls with low-tack adhesive or regular wall vinyl adhesive for more permanent installations. This method reduces the risk of patients obtaining harmful materials. The low-tack adhesive used on smaller images makes it easier to change the art displayed on a seasonal or other basis and allows hospitals to offer patients a choice of artwork

to display in their rooms, giving them some control over their environment.



#482h

c. Seating - Furniture used in behavioral health facilities is preferred to be easily cleaned, easily reupholstered, very sturdy, and as heavy as possible to minimize the likelihood of patients throwing chairs, tables, etc. Where indicated by the Safety Risk Assessment, furniture is suggested to be securely anchored in place or weighted to resist stacking or barricading of doors. Closed arms and legs are preferred to resist attachment of ligatures and breaking into items that could be used as weapons.[482] Upholstered lounge chairs with arms[482] that resemble typical residential furniture are generally preferred, but polyethylene rotationally molded[483] and sand-ballasted seating is now available with a less institutional look. The health care organization should select furniture appropriate for the patient population served and the location on the unit for which it is intended.

#482a

Where movable seating is needed (e.g., dining and activity rooms), very lightweight polypropylene chairs[480] that resist breaking into sharp pieces are preferred. An alternative is a chair that can be partially filled with sand (or otherwise have weight added) to make it difficult to throw or use as a weapon.[480]

#483

Comfort Rooms and other lounge areas may have specialty or chaise lounges[482i] or bean bag[481d] type seating that are manufactured without zippers and with very durable materials and seams.

#480b

Rocking motion has long been believed to be soothing and several companies now offer specially designed seating that allow a rocking motion.[483] Care should be taken to realize that it is not uncommon for unauthorized movement of furniture from a low-level risk area to a higher risk area of a unit to occur. This may result in unintended risks being created.

All upholstery and foam used in furniture should have

#483b

#481

#482i

flame-spread ratings that comply with the requirements of Section 10.3 of ***NFPA*** 101: Life Safety Code® and all other applicable codes and standards.

#485a

d. Furniture:

i. **Tables for dining and activities** are available with enclosed legs[485] and provide less opportunities for ligature attachment. These are usually either center pedestal or "X" base style. Both can be weighted down with sand to reduce the chance that they can be picked up and thrown but can still be movable. A range of styles and shapes of tops are available for both types.

ii. **End tables and coffee tables** are available in enclosed cubes or drums[485c] and other configurations that are also ligature resistant and can be weighted.

#485c

iii. **Shelving units** for items to which patients will have free access are suggested to be sturdy, have open shelves that are fixed in place (not adjustable) and securely anchored in place. The tops of taller units are suggested to be sloped to resist storage and anchored to resist them being tipped over.

5. Fire Suppression

#520a

a. Fire Sprinkler Heads - Institutional heads[520] that are ligature-resistant are preferred.

b. Fire Extinguisher Cabinets - All fire alarm pull stations and all fire extinguisher cabinets[521] are suggested to be locked (with approval of all applicable code authorities). All staff on duty must carry keys for these at all times. These keys should be provided with a red plastic ring or other means of providing quick identification. In addition, fire extinguisher cabinets are preferred to have continuous hinges, recessed pulls (if any), and polycarbonate glazing if view windows are provided.

#521a

6. Plumbing Fixtures and Fittings

a. Toilet Fixtures – Patient accessible toilets are always considered Level IV and V areas and are addressed in those sections.

b. Sinks –

i. **Standard Stainless-Steel Sinks** may be permitted if that is consistent with the organization's Safety Risk Assessment and are suggested to be designed into recesses with doors or roll-down shutters that can be locked when staff are not present.

ii. **Bathroom Sinks** are addressed in Level IV and V sections.

iii. **Hand-washing Sinks** for staff that are in patient accessible areas are suggested to be specially designed units. See subparagraph "h" below.

c. Showers - Patient accessible showers are only permitted in Level IV and V areas and are addressed in those sections.

d. Faucets – Patient use faucets are primarily inpatient bathrooms and are addressed in Levels IV and V. Faucets in activity and similar rooms are addressed in Levels II and III.

e. Flush Valves - Patient accessible flush valves are permitted only in Level IV and V areas and are addressed in those sections.

f. Water Stations – Ligature-Resistant Drinking Water Stations[589] – Drinking fountains are often required or desired in common spaces on units. Typical drinking fountains can be problematic for ligature and infection control reasons but requiring patients to ask staff every time they want a drink of water can rank high on patient dissatisfaction surveys.

To address this issue, consider use of water cup-filling stations in patient-accessible areas. Several options are available for cup-filling stations[589] that have either local or remote refrigeration units, in both wall-mounted and counter-top styles.

#589b

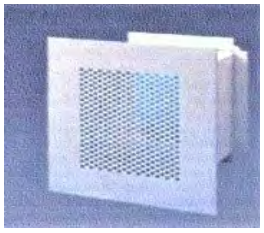
#590c

g. Medical Gases – These are not normally required for behavioral health units. If there is medical necessity or the outlets are a preexisting condition in remodeling projects,

they should be covered with lockable panels[590] or panels attached with tamper-resistant screws. These should be removed only to address the medical needs of the current patient and replaced when that patient is discharged or moved. Special care must be taken in areas where other patients may be present to assure that access to the medical gases does not present a safety risk to them also. Some manufacturers offer lockable covers for outlets.

#545

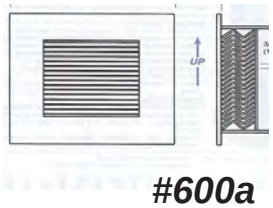
h. **Staff Hand-washing Stations -** Staff Hand-washing stations[545] for patient accessible areas are now available that provide less risk than standard fixtures. These are recessed and have integral soap dispensers and air dryers to eliminate the need for separate dispensers which may also provide risks. All hand-washing sinks that are accessible to patients need to be ligature-resistant.



#602a

7. HVAC

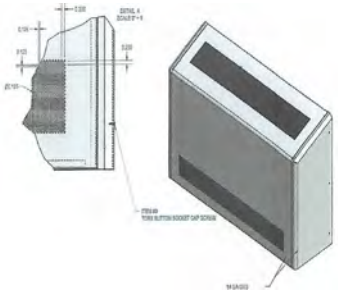
a. **Diffusers, Registers and Grilles -** Grilles with small perforations[602] or with "S" shaped vanes[600] that comply with the National Institute of Corrections standards and are secured in place with tamper-resistant fasteners are generally acceptable in patient accessible areas if allowed by the Safety Risk Assessment.



#600a

b. **Where existing fan/coil units** (as well as fin-tube heaters or old-style radiators) are present in patient accessible spaces, they are strongly suggested to be protected with vandal-resistant covers.[606]

c. **Thermostats –** Existing pneumatic or electric thermostats may be acceptable for use in patient accessible areas if allowed by the Safety Risk Assessment. If they are found to be problematic, there are covers available to reduce the risk of patients tampering with them and gaining access to small parts which they could use to harm themselves or others. However, sometimes these covers draw more attention to the thermostats and encourage tampering. If these become an issue or are an identified risk in the Safety Risk Assessment, consideration could be given to relocating the thermostats to return air ducts or use of aspirating or thermistor units that are mounted behind a stainless-steel cover that is flush with the wall.[607]

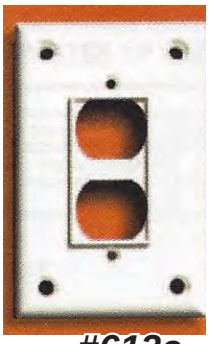


#606

#610

8. Electrical

a. Electrical Devices:



#612c

i. **Receptacles** - In new construction or major remodeling, the ***FGI Guidelines*** require a dedicated circuit for all electrical outlets in each patient room and bath. This will allow power to the outlets in a specific room to be turned off if necessary for a patient's safety. Control of each circuit should be located where only staff have access. Where this is not practical in an existing facility, the outlet may be temporarily covered.

620b

ii. ***FGI Guidelines*** also state that all electrical outlets in patient rooms and patient toilet rooms be a hospital-grade, tamper-resistant type. Use of GFCI receptacles[610] is also preferred to reduce the risk of patients being able to harm themselves by tampering with the receptacles. Arc-fault devices are available and may be provided if required by the Safety Risk Assessment for the patient population being served.

iii. **Cover Plates** - All electrical device cover plates (for switches, receptacles, blank cover plates, etc.) must be attached with tamper-resistant screws.[470] Cover plates made of polycarbonate[612] materials are preferred; polycarbonate cover plates must have screws in each corner to make them rigid enough to resist bending and protect patients from access to electrical wiring and contacts. Nylon cover plates and ones marketed as "unbreakable" are typically not sturdy enough to resist tampering by patients. Standard stainless-steel cover plates that fit tightly to the wall and are rigid may be acceptable for many patient populations if allowed by the Safety Risk Assessment. These may be secured with a single tamper-resistant screw in the center as long as it is securely tightened. The tightness of these screws and fit to the wall is suggested to be included in regular safety rounds documentation.

b. Light Fixtures:

i. **Tamper-Resistant** - All fixtures that can be reached by patients are suggested to be a tamper-resistant type[620] and have minimum ¼"-thick polycarbonate (clear or prismatic) lenses[634] securely fixed in the frame with covers that are firmly secured with tamper-resistant

screws[470] and fit tightly to the ceiling surface. Many such fixtures are now available with LED light sources.

#620c

ii. **LED** - Advances in LED technology have resulted in new options for light fixture designs that can help reduce the institutional character of these spaces. The authors strongly encourage the use of these options and discourage the use of 2'x2' and 2'x4' light fixtures in all patient accessible locations. Our preference is for using linear, round or oval vandal-resistant fixtures for general illumination and recessed security downlights with polycarbonate lenses or small individual reading lights.

iii. **Color Temperature** - The availability of tunable lighting (ability to adjust the color temperature of the light source) is encouraged as is the use of circadian lighting systems.

#624

iv. **Glass Components** that could be accessed by patients are discouraged for use in any fixture. Use of table lamps or desk lamps are also strongly discouraged. Neither incandescent light bulbs nor fluorescent tubes should ever be accessible to patients.

c. **Exit Signs - Lighted Exit Signs[640] or Photo-luminescent Signs[642] –** These are suggested to be vandal-resistant and installed tight to the ceiling with a full-length mounting bracket to avoid use as a hanging device. Mounting these signs on a wall so they are perpendicular to the wall is not recommended because it leaves the top exposed as a possible attachment point.

#640a

9. Communications

a. **Telephone Sets -** Telephones located in corridors or common spaces for patient use should have a stainless-steel case,[645] be securely mounted to the wall, and have a non-removable shielded cord of minimal length (as approved by the Safety Risk Assessment) with cable tether inside the shield. They may be equipped with or without touch pads for placing outbound calls. Some organizations have a switch installed in a staff area to deactivate patient use phones at times when patients are not allowed to make calls.

Some facilities are now providing cordless phones for patient use.

#645a

b. Duress Alarms – Patient to staff injuries are a significant concern in many facilities. One way to address this (other than designing the unit to eliminate locations where staff may become isolated with a patient and become trapped) is to provide some type of personal duress alarm system[650] that staff members can wear and activate when needed. It is preferred that these systems provide information on the location of the staff member when the alert is sent. Some of these can interface with other systems that may already be present in the facility and even use existing wi-fi systems for connectivity.

#650f

10. Electronic Safety

a. Metal Detectors - Some organizations have expressed the desire to use metal detectors to assist with screening patients and/or visitors to their behavioral health facilities. Some choose to use hand-held detectors and others use standard walk-through detectors. Organizations considering metal detection solutions may want to investigate ferrous metal detection systems[660] that sense the presence of ferrous metal in objects such as razor blades, syringes, lighters, cell phones, knives and guns. These systems will not detect drugs or other nonferrous metal contraband items.

#660

11. Exterior Improvements - Outdoor Areas

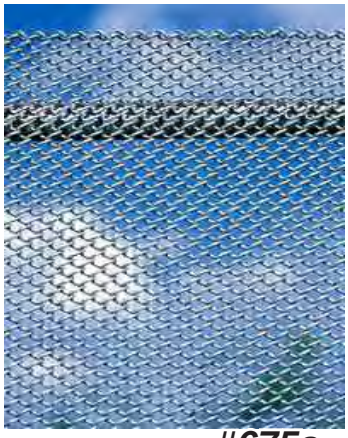
a. Enclosed courtyards, fenced areas adjacent to a treatment unit, or an open campus are considered to have great therapeutic benefit. Because levels of staff supervision for patients using outdoor areas may vary widely between facilities, or even between different groups using the same space at different times, the need for supervision should be carefully reviewed by management early in a design and construction project. The final design for outdoor areas must respond to the acuity and assessment of the most acute patients using the area and the planned staffing levels for each patient population.

b. Fencing - Climbable fences can permit, if not encourage, unauthorized access to windows and roofs or elopement over walls. Buildings, walls, or fences may be used to establish clear boundaries and impede elopement to a

#675d

degree appropriate to the patient population being served. Some behavioral health organizations are comfortable with a perimeter enclosure that is not particularly difficult to climb and simply make elopements a treatment issue if the patients return. Other organizations have a very high need to reduce elopements to the extent possible. Where this is the case, designers may tend to create enclosures that have a very prison-like appearance. If views to the distance are not required, one approach is to treat the outdoor areas as meditation gardens with solid masonry walls that have a smooth interior surface and are 12 to 14 feet high.

i. **Top Fence Protection** - One facility installed large diameter (22”-24”) plastic pipe on top of the wall to make it difficult for patients to get a grip on the top surface. This pipe can be painted to match the color scheme of the building and provides a much less institutional appearance than concertina wire. If views to the distance are desired, “windows” glazed with polycarbonate[201] or security glass[200] may be provided in these walls. These view panels should not have sills or cross bars that could provide toeholds for climbing.



#675a

ii. **Fence Material** - Another option is installation of a fine mesh chain-link fence fabric.[675] This fabric, which comes in a range of sizes down to as small as 3/8” openings, makes the fence more difficult to climb and has openings that are too small for most bolt cutters. When installing such material, fence posts and rails must be strong enough to support the fabric and the wind loading it will add. In at least one instance, a patient successfully climbed a mini-mesh fence, so it is suggested a section at the top be angled inward to further increase the difficulty of climbing at the cost of increasing institutional appearance.

#675b

iii. **Maximum security fencing**,[675b] which has a very prison-like appearance, may be selected for some facilities with involuntarily admitted patients. However, it is suggested that the use of less institutional-looking solutions be explored before deciding to use this type of material.

iv. **Enclosed Courtyard** - Where portions of the building walls will enclose exterior courtyards for patient use, these walls should not be easily climbable, especially if they are only one story high. Windowsills, rain gutters, and similar features may support efforts to climb walls

to gain access to the roof. The exterior surface of all windows patients can access from exterior courtyards must have security glazing,[200] polycarbonate glazing,[201] or security window film,[190] as described under Level II-D.

c. **Outdoor Furniture -** In all cases, careful consideration should be given to exterior furniture used by patients. All outdoor furniture[510] is suggested to be firmly anchored in place. This will resist the furniture from being moved to create barricades or stacked to allow climbing over fences, into windows, or onto buildings. Many types of commercially available furniture can be anchored or are made of concrete or other heavy materials.

d. **Plant Materials -** Shrubbery should be non-toxic and low-growing. Avoid planting shrubbery close together as it can create visual barriers that patients or unauthorized visitors may hide behind. Landscape mulch or decorative rocks that can be thrown to injure staff or other patients should not be used. Trees should be located away from buildings, walls and fences to reduce ease of access to roofs or getting over fences.

e. **Area Drains and Manhole Covers -** All manhole covers, access panels, and area drain grates should be anchored firmly in place to discourage easy removal and use as weapons and to make it difficult for patients to enter the underground piping.

f. **Public Areas -** All areas surrounding patient use buildings, areas where staff will walk or escort patients at night, and courtyards should be well-lighted. Exterior lights should not shine directly into patient room windows. Parking areas for staff and visitors should be well-lighted and reviewed regularly for design features that encourage personal and property security. While security is generally beyond the intended scope of this document, closed-circuit television monitoring and video surveillance recording of these semi-public areas, where there is no expectation of privacy, should be considered.

B. Level I

Areas where patients are not allowed:

All items do NOT need to comply with Baseline conditions but are suggested to meet the following:

1. Comply with all applicable codes and regulations.
2. All service areas should be locked at all times to reduce the possibility of patients entering these spaces.
3. Hardware on doors that connect to a higher Level of Risk (accessible to patients) shall have hardware suitable for the higher level of risk.

C. Level II

Areas behind self-closing and self-locking doors where patients are highly supervised and NEVER left alone which could be counseling rooms, activity rooms, interview rooms, group rooms, exam rooms, as well as corridors that do not contain objects that patients can use for climbing and where staff are regularly present:

Architect of Record - Davis Partnership, Denver,CO: Photographer - Paul Brokering Photography

Architect of Record - Davis Partnership, Denver,CO: Photographer - Paul Brokering Photography

All items same as Baseline with the following exceptions:

Our understanding of The Joint Commission's recommendations at the time of this publication is that the conditions identified in the "***Baseline Considerations for Patient Accessible Areas***" above may be revised as stated below in Level II areas. It is strongly suggested that these revisions only be made after careful consideration and if these variations are consistent with the organization's Safety Risk Assessment. The Safety Risk Assessment should identify all standard items that typically are not allowed on inpatient behavioral health units that are present in rooms that are defined as Level II in this document.

An examination room is required by the FGI Guidelines. When the exam room is located on the unit, the equipment in these rooms present potential risk; therefore suggested to be designated as a Level II with self-closing and self-locking doors. The room is suggested to be large enough to allow several staff to physically manage the patient. If possible, a staff member should not be in the room alone with a patient.

1. Openings

a. Doors - Barricading considerations discussed in Baseline section above are highly recommended for doors to all rooms that patients will enter.

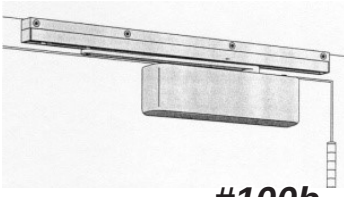
b. Door Hardware:

i. **Self-Closing Self-Locking** - All unattended counseling rooms, interview rooms, exam rooms and other rooms patients may enter only when staff are present are suggested to have self-closing and self-locking doors.

ii. **Storeroom Function** - For Level II rooms to comply with the SRA definition calling for self-locking hardware, are suggested to have "storeroom" function lock-sets with which the doors will always be locked from the outside when closed and latched. The inside lever will always be free.

#100a

iii. **Closers** are needed for Level II rooms which TJC requires to have self-closing and self-locking doors and that staff must ALWAYS be present when patients are in the room. They may be required for other doors by building and life safety codes or because the staff want to assure that a particular doors are not accidentally left open for operational reasons. Where provided, concealed closers[100a] that have the closer and the track both completely contained in the



#100b

head of the door and frame offer the least amount of ligature attachment opportunity (the arm is only exposed when the door is open). However, these require special preparation of the door and frame and are difficult and expensive to provide in existing conditions. Where concealed closers are not practical, it is suggested that surface mounted track closers[100b] be provided and located on the side of the door that either patients are not allowed (Level I spaces) or where the closers are most observable by staff.

2. Finishes

a. Ceilings – Our understanding of current TJC recommendations is that accessible lay-in type ceilings are acceptable in Level II spaces if that is consistent with the organization's Safety Risk Assessment.

b. Wall Base – Standard surface applied thin vinyl or rubber base may be acceptable if that is consistent with the organization's Safety Risk Assessment.

3. Specialties

a. Kitchen Equipment: (Same as Level III except may not need to be lockable if acceptable under the Safety Risk Assessment.)

4. Furnishings

The use of furniture that is lighter weight, easily movable and that has obvious opportunities for ligature attachment in Level II rooms may be acceptable to TJC and can be considered for use if it complies with the findings of the Safety Risk Assessment performed by the organization.

The health care organization should select furniture appropriate for the patient population served and the location on the unit for which it is intended. Care should be taken to realize that it is not uncommon for unauthorized movement of furniture from a low-level risk area to a higher risk area of a unit to occur. This may result in unintended risks being created.

a. **Seating -** Open arms and legs on un-weighted furniture that is not securely fixed in position may be acceptable if consistent with the Safety Risk Assessment. High-quality wood, steel or plastic chairs for use at tables may be more standard products. Upholstered lounge chairs[482] that resemble typical residential furniture are generally preferred.

b. **Tables** may be more typical style[485], have individual legs at the corners and be easily movable to accommodate a range of uses and activities; consideration for weighted tables for Level II areas.

c. **Bookcases and Cabinets -** Same as Baseline except as may be allowed by Safety Risk Assessment for areas behind self-closing and self-locking doors as discussed above.

#482j

#485b

6. Plumbing Fixtures and Fittings

a. **Toilet Fixtures -** Level IV and V areas only

b. **Sinks –** Standard stainless-steel sinks may be permitted if that is consistent with the organization's Safety Risk Assessment, but caution is recommended.

c. **Showers -** Level IV and V areas only

d. **Faucets -** Standard goose-neck faucets and standard valve handles may be permitted in activity and similar areas that are consistent with the organization's Safety Risk Assessment, but caution is recommended.

e. **Flush Valves -** Level IV and V areas only

f. **Medical Gases -** Not typically present in Level II areas

7. HVAC

a. **Diffusers, Registers and Grilles –** Standard products may be acceptable if that is consistent with the organization's Safety Risk Assessment. Products consistent with Level III suggestions are recommended.

b. **Thermostats –** Standard products may be acceptable if that is consistent with the organization's Safety Risk

Assessment. Products consistent with Level III suggestions are recommended.

8. Electrical

a. Electrical Devices: Standard products of this type may be acceptable if that is consistent with the organization's Safety Risk Assessment.

b. Light Fixtures –

#630

i. **Standard products** may be acceptable if that is consistent with the organization's Safety Risk Assessment. Products consistent with Level III suggestions are recommended.

ii. **Covers**[630] are available for existing (or new) downlights that are secure and make the appearance more residential in nature.

iii. **No glass components** should be exposed to patients in any fixture and use of table lamps and desk lamps is strongly discouraged.

c. Exit Signs - Standard products may be acceptable if that is consistent with the organization's Safety Risk Assessment. Products consistent with Level III suggestions are recommended. The mounting bracket suggested to be full length of the fixture.

d. Security Lighting - Standard products may be acceptable if that is consistent with the organization's Safety Risk Assessment. Products consistent with Level III suggestions are recommended.

D. Level III

Areas that are <u>not</u> behind self-closing and self-locking doors where patients may spend time with minimal supervision such as open lounges, day-rooms and corridors where staff are not regularly present. Open nurse stations are suggested to be considered under this Level because there may be incidents where staff will not always be present in these spaces:

Architect of record: Progressive AE, Grand Rapids, MI - Photographer: JRP Studios

Architect of Record - Davis Partnership, Denver,CO: Photographer - Paul Brokering Photography

Architect of Record - Bernstein & Associates, New York, NY - Photographer: Paul Warchol

This document is intended to represent leading current practices, in the opinion of the authors. It does not represent minimum acceptable conditions or establish a legal "standard of care" that facilities are required to follow.

All items shall be the same as Baseline with the following exceptions:

3. Specialties

a. Kitchen Equipment: (Typically Levels II and III only) -

All cooking appliances (ranges, microwaves, coffee makers, etc.) should have key-operated lockout switches[611] to disable the appliance. If these and other appliances, such as refrigerators, have open handles that could be used as ligature attachment points, and they are in areas where patients have unsupervised access to them, provisions should be made to close them off with overhead coiling doors or other means.

#611

i. Patient access to coffee should be carefully considered in each facility's Safety Risk Assessment (SRA). If access to this (and other potentially scalding liquids) is allowed, an insulated plastic dispenser should be located so it is readily observable by staff. Glass coffee pots should never be available to patients.

ii. All garbage disposal units should have a key-operated lockout switch[611] to disable the device.

iii. All receptacles located near sources of water, including sinks, as well as all patient-accessible receptacles must be GFCI-protected as required by applicable codes.

b. Television Set Enclosures (Typically Levels II and III only) -

Television sets should not be mounted on walls using exposed brackets because of the ligature risk this presents. Rather, all TV sets should be installed in built-in TV or media centers or manufactured tamper-resistant covers with sloped tops.[290] Some facilities prefer to also have an isolation switch that staff can control. For maximum safety, the electrical outlet and cable TV outlet should be located inside the cover to keep the wires and cables away from patients.

#290a

4. Furnishings

The health care organization should select furniture appropriate for the patient population served and the location on the unit for which it is intended. Care should be taken to realize that it is not uncommon for unauthorized movement of furniture from a low-level risk area to a higher risk area of a unit to occur. This may result in unintended risks being created.

#480b

a. Seating - Closed arms and legs on furniture that is weighted or is securely fixed in position may be preferred when consistent with the Safety Risk Assessment. High quality plastic chairs for use at tables may be acceptable. Lounge chairs with upholstery[482] that resemble typical residential furniture and meet the criteria above are generally preferred.

#482a

b. Tables[485] are suggested to <u>not</u> have individual legs at the corners and be weighted or anchored in place to resist being thrown or stacked.

c. Bookcases and Cabinets - Same as Baseline.

#485a

6. Plumbing Fixtures and Fittings

a. Toilet Fixtures - Not permitted in Level III areas

b. Sinks – Standard stainless-steel sinks may be permitted if that is consistent with the organization's Safety Risk Assessment, but caution is recommended.

c. Showers - Level IV and V only

d. Faucets - Standard gooseneck faucets and standard valve handles may be permitted if that is consistent with the organization's Safety Risk Assessment, but caution is recommended. In Level III areas consideration is suggested to locating these sinks behind lockable doors or roll-down shutters that are closed and secured when staff are not present.

e. Flush Valves - Level IV and V only

f. Medical Gases - Level IV and V only

g. Diffusers, Registers and Grilles - Standard grilles are <u>not</u> recommended in Level III areas. Grilles with "S" shaped vanes[600] are preferred.

E. Level IV

Areas where patients spend a great deal of time alone with minimal or no supervision:

Level IV-a. Patient Rooms

Architect winning design competition: HDR, Omaha, NE - Photographer: VA Photo, Scott R. Snell

All items shall be the same as Baseline with the following exceptions:

1. Openings

a. Doors:

i. **Patient Room Doors** continue to be one of the most frequently used items in suicide attempts in these facilities. This is verified in ***TJC***'s "Incidence and Method of Suicide" study dated July 2018.

Barricade resistant strategies discussed in the Baseline section are strongly suggested to be used in these locations.

ii. **Abuse -** These doors also frequently receive abuse and use of the more durable synthetic faced doors[25] in these locations will help retain their appearance.


#25a

b. Door Hardware:

i. **Handles** on lock-sets are especially important on these doors. Careful consideration of the risks involved in compliance with the Safety Risk Assessment is strongly suggested.

ii. **Hinges** need to be carefully coordinated with the barricade resistant solution selected and over-door-alarm system, if provided. These need to be thought of as an assembly, not separate parts that can be put together in any combination.


#150a

iii. **Over-the-door alarms**[150] are strongly suggested for patient room to corridor doors. Since the building and life safety codes require these doors to be tight-fitting for smoke and other reasons, the top of these doors is one of the attachment points most frequently used in suicide attempts. The bottom of doors can also present a risk if the gator roll technique is attempted. One product will detect this also.

iv. **Locks** - Some facilities have begun to address the desire of some patients to lock themselves in their rooms to avoid unwanted entrance by other patients. The challenges with this are to provide individual security for the patient without restricting staff access to the room. Options include lock-sets with specialized locking functions and ligature-resistant turnpieces[140] that cannot be held from inside the door to resist a key being turned to unlock the door. A cylinder protector[141] to cover the lock cylinder on the corridor side of the door resists attempts to insert objects in the key-way. Card access technology is also available to control these locks.

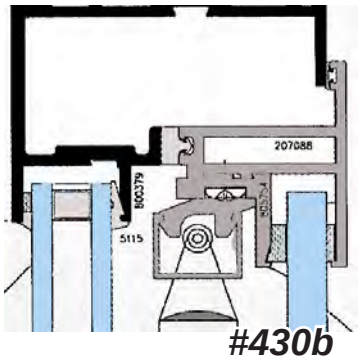
#140

c. Windows:

– Advances in different types of safety glass make it worthwhile to consult an expert for advice for a specific project. The height above the ground, patient population, and many other factors should be taken into account in choosing these materials. Comply with the FGI Guidelines and all applicable codes and regulations for glazing, frame installation and operable sash.


#141a

If replacing windows presents a prohibitive cost in remodeling work, a security screen with a very sturdy steel frame[80] designed to resist deflection and equipped with multiple key locks and a heavy-gauge stainless steel screen fabric[81] may be used. These are functional and secure but create an "institutional" appearance and can be defaced by writing obscene words with toothpaste (or other material). Patients have also been known to use the rough surface of the screen fabric to abrade their skin



#430b

i. **Exterior Windows** - Mini- blinds[430] or roller blinds[440] behind safety glazing is strongly suggested for these rooms. Ligature resistant control of the blinds can either be by staff only or by both patients and staff as indicated by the Safety Risk Assessment.

ii. **Interior Windows** – The provision of view windows between patient rooms and corridors is usually discouraged for patient privacy reasons. The use of windows (either in doors or walls) as a method of performing routine patient checks at night is discouraged because it is often very difficult to observe the patient sufficiently. If these windows are provided, it is strongly suggested that they have either mini-blinds[220] between Security glass or glass that can be made opaque electrically.[221] Either type of control is preferred to be by staff only to restrict patients' ability to peek in on other patients.

#220c

iii. **Operable Windows** – These are not usually required in patient rooms but may be provided if desired by using products that reduce the risk of elopement and passing of contraband[434] (if on the ground floor).


#434a

d. Glazing – Security glazing[200] is strongly suggested for these rooms.

e. Window Coverings – See Baseline

2. Finishes

a. Walls – Impact and/or abrasion-resistant gypsum board[230] installed on minimum 20-gauge metal studs spaced no more than 16 inches on center; paint finish preferred. Sound-

attenuating gypsum board[232] may also be used on walls if approved by the manufacturer for use in behavioral health applications.

b. Ceilings – ***The FGI Guidelines*** currently require "monolithic" ceilings in all patient bedrooms, bathrooms, bathing facilities and seclusion rooms. Their definition of this term virtually requires the use of solid gypsum board[230, 232] ceilings.

#30b

These monolithic ceilings are suggested to have key-lockable access panels[30] that fit tightly to their frames. Larger sizes of these panels, may require tamper-resistant screws in the corners or along the sides of the panels. Pick-resistant caulk may be needed if the flanges of these panels do not fit tightly to the ceiling or wall surface.

Other tamper-resistant systems[239] discussed in Baseline section do not appear to meet this definition.

c. Wall Base - See Baseline

d. Flooring – See Baseline: If some patients are prone to urinate on the floor, provide some rooms with seamless epoxy[250] or sheet vinyl flooring with an integral cove base. Metal or plastic strips should not be applied at the top edge of the base. Use of a system that eliminates the need for trim strips[250c] is recommended.

e. Special Wall Surfacing – Wall protection panels[320] are sometimes used in these areas, but the use of plastic or metal trim strips are strongly discouraged.

3. Specialties

a. Cubicle Curtains and Tracks – These are not recommended for use in behavioral health facilities because of the risk they present. If non-ambulatory patients with co-existing medical conditions are being treated on these units, it is recommended they be assigned to single-patient rooms.

4. Furnishings

a. Seating:

i. **Desk chairs** are preferred to be lightweight[481] or ballasted[480] as discussed in Baseline Considerations.

ii. **Stools**[479] that are specially designed for use in behavioral health units are also available.

#480b

b. Furniture:

i. **Sturdy wood, thermoplastic, or composite furniture should be bolted to the floor or walls whenever possible.** Care must be taken to assure the furniture will withstand abuse, will not provide opportunities for hiding contraband, does not have joints that will allow penetration of liquids such as urine, and will resist being dissembled to provide patients with weapons.

#479a

Open-front units with fixed shelves and no doors or drawers[495] are recommended. Doors should not be provided because they can be used by patients as ligature attachment points. Drawers should not be provided because they can be removed by patients and broken to use as weapons. All upholstery and foam used in furniture and mattresses should have flame-spread ratings that comply with the requirements of NFPA 101: *Life Safety Code*, Section 10.3.

#495

ii. **Beds**

- **Non-Adjustable Platform Beds**[493] – Beds without wire springs or storage drawers are preferred. These beds should be securely anchored in place to prevent patients from using them to barricade the door. If a portable lifting device will be used, beds are available with an opening underneath to accommodate the legs of the lift.[494] Portable lifts can also be accommodated by placing an existing platform bed on a specially designed riser; this arrangement also reduces the amount of bending over staff need to do to work with the patient.[494b]

#493f

- **Mattresses for Platform Beds**[492] – These should be specifically designed for use in behavioral health facilities and be resistant to abuse and contamination.

- **Bedding**[491] - If bedding other than standard sheets are indicated by the Safety Risk Assessment for some patients, one piece durable products are available,

#492e

- **Electric Hospital Beds** – If electrically operable beds are needed for patients with co-existing medical issues or to reduce risk of staff injuries, beds that are specifically marketed for use on behavioral health units[490] should be used rather than standard electrically adjustable hospital beds. These specialty beds will sense obstructions and reverse direction and have lockout features for the controls, reduced-length cords, and other tamper-resistant features. However, they do have significant ligature attachment point risks with the guard rails, headboard, foot board and allow access to many hazards beneath the bed.

#491a

- **If existing electrically operable beds** must be used for financial reasons, use only beds that require a constant pressure on a switch located on the bed rail (not a remote-control device or paddle that can be placed on the floor). Also, provide a key lockout switch[611] on the beds (or a removable pigtail) so only staff can operate the beds. All electrical cords should be secured and shortened. These beds also have significant ligature attachment risks as mentioned above.

#490d

- As for **other wheeled beds**, the wheels of electric hospital-type beds should be removed or rendered inoperable. It is further suggested that corridor doors to rooms with electrically operable beds be locked at all time the patient is not in the room to reduce the risk of other patients entering the room and harming themselves.

iii. Wardrobes – Wardrobe units should not have doors and should have fixed (non-adjustable) shelves.[496] They should be securely anchored in place and have sloped tops. Wardrobes with clothes poles requiring hangers are discouraged because, although the bar can be made safe, the hangers present serious hazards. The ***FGI Guidelines*** no longer call for patient rooms to have accommodations for “hanging full-length clothing.” The average length of stay in many facilities is now in the

#496

7-to-10-day range, and patients seldom come with clothing that needs to be hung up. The use of clothes hangers is not recommended.

iv. **Cabinets (Built-in) –** if provided, these are strongly suggested to have no doors or drawers and any shelves be securely anchored in place to resist both upward and downward force.

- One exception to not having cabinet doors may be cabinets to hold CPAP machines[496c] in some patient rooms if allowable by the facility's Safety Risk Assessment. These have a slot to allow the tubing to exit the cabinet. Care is suggested in locating these and consideration of other patients who may have access to the tubing. It is suggested that if these are provided they be equipped with concealed hinges, key operated locks, ligature resistant pulls and be designed so the doors resist ligature attachment when closed and locked. The electrical receptacle to operate the machine is strongly suggested to be located inside this cabinet.

496c

6. Plumbing Fixtures and Fittings

a. Toilet Fixtures - Levels IVb and Vb only

b. Sinks – Hand washing sinks are not required in Psychiatric Hospital patient rooms by the FGI Guidelines but toilet rooms are required to have sinks by the FGI Guidelines and are covered in Level IVb.

c. Showers - Levels IVb and V only

d. Faucets - Levels IVb and V only

e. Flush Valves - Levels IVb and V only

f. Water Stations – Levels II and III only

g. Medical Gases – These are not normally required for behavioral health units. If there is medical necessity or the outlets are a preexisting condition in remodeling projects, they are suggested to be covered with lockable panels[590c] as listed in Baseline above or panels attached with tamper-resistant screws. These covers should be

removed or opened only to address the medical needs of the current patient and replaced when that patient is discharged or moved. Special care must be taken in semi-private rooms to assure that access to the medical gases does not present a safety risk to the other patient. Some manufacturers offer lockable covers for outlets. Cabinets that are large enough to enclose the devices attached to the outlets[590b] are preferred.

#590b

7. HVAC

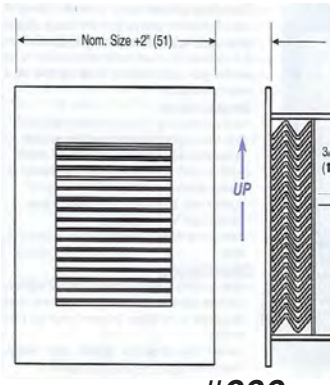
a. Diffusers, Registers and Grilles:

i. **Fully recessed vandal-resistant grilles** with S-shaped air passageways[600] are recommended for all ceiling and wall-mounted grilles. Perforated air grilles are not suggested for Level IV areas.

#590c

ii. **HVAC Equipment** - In new construction or major remodeling projects, locate individual room HVAC equipment (such as fan/coil units) in an adjacent corridor or another location (e.g., an interstitial space) where they can be serviced without entering the patient room.

iii. **HVAC Equipment** - If individual fan/coil-type units exist and must remain, they should be protected with vandal-resistant covers[606] the same as for corridors in all other Levels.



#600a

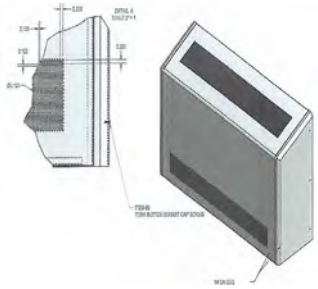
b. Thermostats –

See Baseline and as called for in the Safety Risk Assessment.

8. Electrical

a. Electrical Devices:

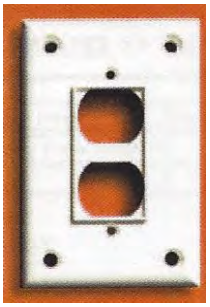
i. **New construction or major remodeling** - the ***FGI Guidelines*** require a dedicated circuit be provided for all electrical outlets in each patient room and bath. This will allow power to the outlets in a specific room to be turned off if necessary for a patient's safety. Control of each circuit should be located where only staff have access. Where this is not practical in an existing facility,



#606

a tamper-resistant temporary cover may be installed when necessary.

ii. **All electrical switch and outlet cover plates** should be as discussed in Section A - Baseline Conditions.



#612c

b. Light Fixtures –

i. **Standard Fixture** - The standard general hospital practice of providing a 2'x4' light fixture directly over patient beds is seldom needed in behavioral health facilities because medical treatment is not provided in the patient beds and looking up into one is not very pleasant.

ii. **LED Fixture** - The current preference is for using either wall or ceiling mounted narrow strip LED fixtures.[620d] An alternative can be round or oval vandal-resistant fixtures[620k] for general illumination. Many of these fixtures are now available with LED light sources and some are tunable to allow patients or staff to change the color or the light.

#620h

iii. **Downlight** - Any downlights are suggested to have polycarbonate lenses.[620h]

iv. **Small individual reading lights**[624] can be provided to give reading light near beds or adjacent to built-in bench seating areas or allow patients to turn on a small light to assist when getting up in the middle of the night.

#624

v. **Night Lights**[539] – are required by the ***FGI Guidelines*** in patient rooms and these are to be controlled from a location near the door to the room.

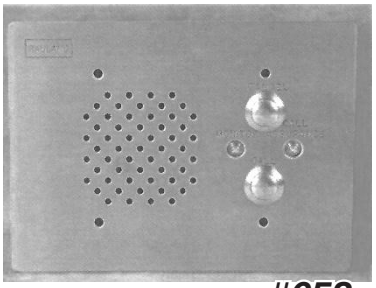
#639a

9. Communications

a. Telephone Sets are not typically provided in behavioral health patient rooms.

b. Nurse Calls are not required in behavioral health patient rooms by the FGI Guidelines; however if they are provided, they are required to meet their standards and are suggested to have flush mounted push button activation.[653]

If cords are provided, it is recommended they be no longer than 6" and as lightweight as possible.



#653

Level IV-b. En-suite Patient Toilet Rooms:

Architect of Record - Davis Partnership, Denver,CO: Photographer - Paul Brokering Photography

All items shall be the same as Baseline with the following exceptions:

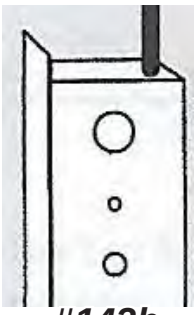
1. Openings

a. Doors & Hardware - The first question to address for patient toilet room doors is whether the facility ever has the need/desire to lock patients out of their bathrooms.

#113c

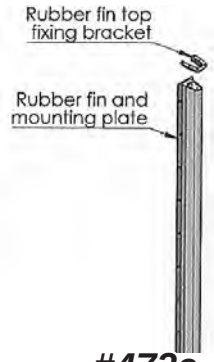
i. Locking - If there is a need to lock patients out of the bathroom:

- **Double-acting Hinge** - A full-size, tight fitting, out-swinging door mounted on a double-acting continuous hinge[113c] with cap and over-door alarm[150] is preferred. Also, a classroom function deadbolt that extends the bolt into the head of the door frame (with a ligature-resistant turn piece on the inside that will retract the bolt but not extend it[143b]), two flush pulls[121] mounted back to back (larger pulls[121d] available for ADA accessible rooms), and a roller,[147] ball[146] or magnetic[148] latch at the head should be installed along with a rubber fin with top fixing bracket[473e] mounted on the strike side of the frame.



#143b

- **A sliding door**[40g] that is ligature resistant can eliminate issues with swinging door conflicts or floor space issues as long as there is wall surface for it to slide over in the open position. Ligature resistant pulls and locking hardware are available for this configuration. A frame assembly is now available for this system to assist with installation on existing openings.



#473e

ii. Non-Locking - If it is not necessary to lock patients out of their bathrooms, one of the following options may be provided:

- **Non-lockable doors** eliminate many of the hanging hazards associated with a typical door. Some attach with magnets[470a] (*illustrated on next page*) and may be easily removed by staff for use as a shield against an attacking patient.

- **Door assemblies with sloped tops**[473c], continuous hinges and rubber fins at the strike jamb and ligature resistant pulls are another option.

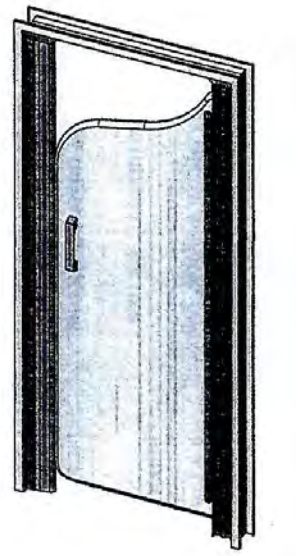
#40g

- **No Door** - Some facilities with single-patient rooms are electing to remove doors entirely from patient toilet rooms. The practicality of this depends on not having a clear sight line into the toilet room from the corridor door. This has proven to be unpopular with patients in some facilities due to the lack of privacy.

#470a

iii. **Shower Openings - Doors** – No shower curtains or their tracks of any type (including those designated as "breakaway" and represented by their manufacturers as "safe for psychiatric hospitals") are recommended for use in any patient-accessible areas, especially patient showers. In new construction, showers could be designed to contain the spray within the compartment without the use of a curtain or door. The use of foam doors[470a] or hard plastic doors[473c] mounted with a minimal gap between the bottom of the door and the floor may be used to reduce the amount of water that leaves the shower compartment.

The use of residential glass shower doors is specifically discouraged.



#473c

2. Finishes

a. Walls – The following are suggested depending on the acuity of the patient population and the project budget:

i. **Synthetic wall protection panels**[331] (without trim pieces) or solid-surface sheet material

ii. **Ceramic or porcelain tile** in large pieces

iii. **Gypsum board** that is impact-resistant and has mold and moisture-resistant facing[230] with epoxy paint; solid-surface sheets in showers.

b. Ceiling – Gypsum board with mold- and moisture-resistant facing[230] with epoxy paint is recommended.

c. Wall Base – See Baseline

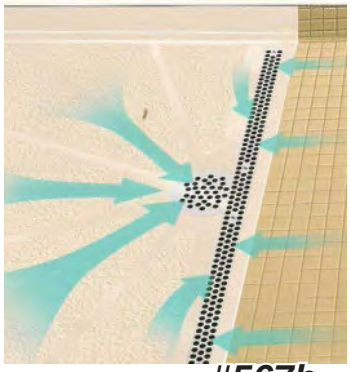
d. Flooring – One of the following slip-resistant products may be used depending on the acuity of the patient population and the Safety Risk Assessment :

#250a

i. **Seamless Epoxy Flooring**[250] – This flooring should have a slip-resistant finish and integral cove base and can be used in a shower. Do not use a metal or plastic strip at the top of the base as patients can remove it for use as a weapon.

ii. **Ceramic and Porcelain Tile** - Larger tiles may be used (to reduce the number of joints) as long as the installation is maintained in good condition.

iii. **One-Piece Floor Units** – These units[564] provide a monolithic floor (European-style) for the entire patient toilet room that drains the shower to a central location. If used in conjunction with location of the shower enclosure and shower head, this unit can eliminate the need for shower curtains.


#567b

iv. **Solid-Surface Material Basins** – These are available with a trench drain[567] across the entire front opening of the stall, which not only helps keep water from getting into the room, but also makes the drain more difficult for patients to intentionally clog. Fiberglass shower stalls and floors are generally not durable enough.

v. **Prefabricated Bathrooms**[568] – These contain all finishes, fixtures, and accessories and can reduce construction time because they are shipped to the site ready to be connected to the utilities. Care must be taken for use of durable materials.


#568a

3. Specialties

a. Toilet Accessories –

i. **Robe Hooks** – Evaluate the risk of using these hooks. If they are required, they should be the collapsible type.[350]

ii. **Towel Bars** – Use collapsible hooks[350] instead of towel bars for towels.

iii. **Grab Bars** – Because some patients may be on medications that interfere with their equilibrium, grab bars for toilets and showers are recommended for all patient-


#350e

accessible toilets. A self-draining bar[332] may be installed on a slight slope. These provide a high degree of safety and are also easy to clean and sanitize. If the wall surface behind the bar is not smooth and flat, provide pick-resistant sealant to the joint between the bar and the wall.


#332b

iv. **Vertical Grab Bars** – In locations where vertical grab bars are required or desired, typical ligature-resistant bars mounted vertically can usually be grasped only from one side. A ligature-resistant grab bar specifically designed to be mounted vertically[337] that can be grasped from either side is available.


#337

v. **Soap Dishes** - These should not have handles and should be recessed. Soap dishes that can be installed from the front [390a] should be provided unless there is access to the chase behind the wall for installation

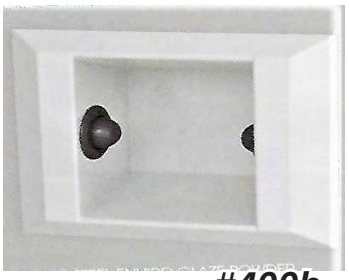

#390a

vi. **Soap Dispensers** – Many facilities now use liquid or foam soap in patient areas, but the commonly used hard-plastic soap dispensers are problematic in that they are fairly easy to pull off the wall and break into sharp shards that can be used as weapons. At least one manufacturer now offers steel covers for their standard dispensers. Another solution is a dispenser made of solid-surface material[391] commonly used for counter tops that is relatively tamper-resistant. Some commercially available stainless steel dispensers are reasonably ligature-resistant.

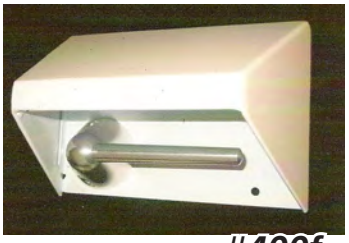
#391b

vii. **Toilet Paper Holders:**

- **Toilet paper holders**[400] that do not require a bar or tube to hold the paper allow for standard use of the roll of toilet paper without requiring everyone using the roll to handle it. They are available in recessed and surface mounted styles and some have no moving parts.


#400b

- **Other toilet paper holders** use a bar(s) that pivot down[400f,g] when vertical pressure is imposed.


#400f

viii. **Shelves** – Shelves to hold miscellaneous items are often requested in shower stalls and near wall-hung lavatories. A stainless-steel suicide-resistant shelf that

is either surface-mounted[371] or recessed into the wall[, 370] may be considered for these applications. Front mounted recessed units are preferred unless access to the chase is provided.


#370a

ix. **Paper Towel Dispensers** – Paper towel dispensers are a concern in patient-accessible toilets because they typically are constructed of light-weight materials that can either be broken or bent to form sharp objects that may be used as weapons. Alternatives are as follows:

- Place a small stack of paper towels on a surface-mounted or recessed shelf.
- Provide a heavy-gauge, vandal-resistant dispenser.[340b]
- Install a heavy-duty secure cover[340a] over a standard-weight paper towel dispenser.
- Install a polycarbonate, vandal-resistant dispenser.[340c]


#340b

b. Mirrors – There are several options now available.

i. Glass-laminated polycarbonate mirrors in ligature resistant wood frames offer an option with a residential appearance and are scratch resistant. (See also A.3.e.i)


#340a

ii. Polycarbonate mirrors with built-in lighting are attractive and non-institutional but are susceptible to scratching.

iii. Typical radiused stainless steel-framed security mirrors[360] are available with polycarbonate, tempered glass, stainless steel, or chrome-plated steel reflective surfaces. Each has different durability and distortion characteristics. Some framed mirrors have a flat surface on top which may be a ligature attachment point.


#360a

6. Plumbing Fixtures and Fittings

a. Toilet Fixtures - Toilets used by behavioral health patients should be a floor-mounted, back water supply type rather than a wall-mounted fixture, which can be broken off its hangers and may present a ligature attachment risk. These type fixtures are available in china, stainless steel and solid surface material. Where wall-hung toilets or floor


#531a

mounted fixtures that do not fit tightly to the wall exist and replacing them is not practical, some facilities have had stainless steel or solid surface filler panels custom fabricated to fill the voids.

#534b

i. **Movable seats** provide attachment points for ligatures, so their use should be considered carefully by each hospital. The solution is to use a fixture with an integral seat as suggested above[534b]**.** Some facilities feel this is too prison-like and choose to accept the risk of the movable seat. At the present time, TJC is allowing movable toilet sets in behavioral health facilities.

#533

ii. **China fixtures** themselves (both floor- and wall-mounted) can be broken into large, sharp shards. Toilet fixtures made of solid-surface material[533] and stainless steel[534] are available and are much more resistant to breakage. The stainless steel fixtures can be powder-coated for a less “institutional” appearance.

#536

iii. **Bariatric -** Toilet fixtures that manufacturers claim will support loads in excess of 2,000 pounds are available if needed for patients of size.[536]

b. Sinks:

i. **Solid Surface -** Typical commercial solid-surface counter tops with integral sinks offer a much less institutional appearance. They also provide a place for patients to set their toothbrushes, etc. Specialty vanity top-type lavatories[542] provide many of the same benefits.

#540a

ii. **Wall-Hung Solid-Surface Lavatories** – Corner lavatories[540] make ligature attachment difficult and some come with the ADA required 18” space from the wall to the centerline of the drain and matching pipe enclosure.

iii. If a **wall-hung fixture** is used that does not fit into a corner,[541] the optional filler panel is recommended to fill the space between the side of the fixture and an adjacent wall when there is one near the fixture. Stainless steel or high-impact polymer pipe covers designed for the lavatories that fit tightly to the bottom of the fixture should also be provided.

#541a

iv. **Lavatory Waste and Supply Piping** – All piping of this type must be enclosed so it is not accessible to patients.[410] Extreme care should be taken to trim the

enclosing material so it fits tightly to the underside of the lavatory fixture to prevent the patient from using this space to hide contraband.

#410a

c. Showers:

i. **Shower Heads** – These should be a ligature-resistant institutional type.[550] ADA Handicapped-accessible showers are required to have either a hand-held shower head or a second, lower head 48" above the floor. The hand-held shower head should be on a ligature-resistant, quick-disconnect fitting[563b] that allows removal of the head and attached hose when not in use. If a hook is provided to hold the hand-held shower head, it should be mounted on the part of the fitting that is removed when the hose is removed. A ligature resistant shower head with integral quick-disconnect fitting and internal diverter valve[553a] is available which reduces the clutter of individual items. Another option is to provide a lockable cabinet to house the hand-held head and valve.[562]

#563a

ii. **Shower Control Valves** - *Note:* Provide thermostatically limited hot water to prevent accidental or intentional scalding in all patient-accessible sinks and showers.

- **Single-knob mixing valves** that provide minimal opportunity for tying anything around them are preferred.[552] These give patients control of the water temperature and duration of flow. Some of these are claimed to be ADA-compliant by their manufacturers.

#552b

- If it is only necessary to **replace the valve handles** and the valve itself is working properly, use of a replacement valve handle[552c] that can be adapted to a variety of valves might be considered. *Note:* This may void any remaining warranty on the existing valve.

- A "**no-touch" valve**[552e] that appears to be ADA compliant is available. It utilizes infrared controls to give patients control of a range of water temperatures and the duration of flow.

- **One-piece shower assemblies** that contain shower heads, valves, and a recessed soap dishes[560] work well for remodeling projects because they reduce the amount of repair needed for wall finishes. These

#560c

are also available with a second head[563c] located 48" above the floor and a diverter valve if needed for ADA purposes.

iii. **Shower Drains –** That offer less opportunity for ligature attachment or patients abrading their skin[565] are preferred over more traditional drain grates.

#565c

iv. **Diverter Valve** – If a diverter valve is needed to change the water flow from the standard shower head to the ADA-required head, a ligature-resistant diverter valve[555] may be provided.

#570

d. Faucets - Lavatory and Sink Faucets and Valves – Faucets and valves can provide attachment points for ligatures. A lavatory valve unit is now available that uses a shower valve fitted with a ligature-resistant handle[574] to allow patients to control the temperature (thermostatically limited to prevent scalding) and duration of the water flow. This valve can be used to replace the motion sensor activation of some faucets. Faucets are available in a variety of materials and configurations that range from push-button to motion sensor-activated.[570] Faucets with two push buttons allow patients some choice of water temperature and do not require electricity (either battery or line voltage) to operate. They also will not automatically turn on unexpectedly, which is disturbing to some patients.

#581b

e. Flush Valves – Toilet flush valves that are recessed in the wall[580] and activated by a push button[581] are preferred. Where this is not practical, the flush valve and all related pipes should be enclosed with a stainless steel[585] or plastic[585b] cover with a sloped top that incorporates a push-button activator for the valve. Sensor activation of flush valves is discouraged because they require electricity (either battery or line voltage) and may flush unexpectedly which can be disturbing to some patients.

#585a

7. HVAC

a. Air Grilles – Perforated air grilles are not suggested for Level IV areas. Grilles with "S" vanes are preferred. See Section A Baseline Conditions.

8. Electrical

a. Electrical Devices:

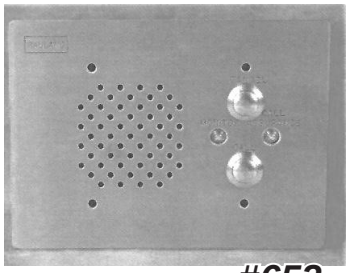
i. In new construction or major remodeling, the ***FGI Guidelines*** require a dedicated circuit be provided for all electrical outlets in each patient room and bath. This will allow power to the outlets in a specific room to be turned off if necessary for a patient's safety. Control of each circuit should be located where only staff have access. Where this is not practical in an existing facility, a tamper-resistant temporary cover may be installed when necessary.

ii. **All electrical switch and outlet cover plates** should be as discussed in Baseline.

b. Light Fixtures – These fixtures require wet condition rating and are otherwise the same as Baseline.

9. Communications

a. Nurse Calls – These are not required by the ***FGI Guidelines***, but if they are provided, they must meet general hospital standards. In addition, flush mounted push-button activation is preferred.[653] In areas where falls may occur, it is recommended that a second push button located about 12" above the floor be provided below the one at normal mounting height. If pull cord activators are provided, the ***FGI Guidelines*** limit their length to a maximum of 6 inches in length.



#653

F. Level V:

Areas where staff interact with newly admitted patients who present potential unknown risks or where patients may be in highly agitated condition, such as Admissions, and Seclusion/Restraint Suites:

Level V-a. Admissions:

Architect of Record - Davis Partnership, Denver,CO: Photographer - Paul Brokering Photography

All items shall be the same as Level IV with the following exceptions:

If possible, the admissions function is preferred to not take place on an inpatient unit. At admission, unit staff members know very little about a new patient and his or her trigger points. A separate location for admission avoids disrupting either the unit or the new patient due to the agitation of either.

The Admission rooms should be pleasant, calming, quiet and welcoming; and should be minimally furnished (with a few loose pieces of furniture).

The room should be large enough to allow for several staff to physically manage the patient if necessary. If possible, the admitting staff member should not be in the room alone with a patient. After the admitting process is complete, the patient can be escorted to the unit. These precautions are particularly important for emergency admissions, which frequently occur at night and on weekends.

1. Openings

a. Doors - As stated above, all rooms patients will enter are suggested to have a barricade-resistant solution as discussed in Baseline.

b. Windows:

i. Exterior – If exterior windows are present, they are suggested to comply with comments for Level IV above.

ii. Interior - Provide a small (12”x12” or 4”x24”) view window in the door that can be controlled by staff[220] from outside the room to observe what is happening in the room when necessary and resist non-authorized individuals having visual access to the room.

Diagram #1

4. Furnishings

a. Cabinets (Built-in) - Same as discussed in Baseline.

b. Seating –

i. The furniture arrangement is suggested to locate the patient’s and family member’s chair(s) so that when they are seated, they will not be between the staff member and the door to the room.

Chairs[482] are preferred to be comfortable and fixed in place or heavyweight as discussed in Section A Baseline Concepts.

#482

ii. Desk Seating for staff[480] is suggested to be a lightweight plastic chair in lieu of a standard desk chair which could be used as a weapon.

b. Furniture:

i. If a built-in desk or table is provided, it is preferred to be sturdy and firmly attached to the floor or walls and contain a lockable file drawer for forms and a lockable box drawer for pens, pencils, staplers, etc. All loose items should be kept in drawers and out of sight.

#480b

ii. The use of laptop or tablet computers in these rooms is preferable to minimize cords and wires that patents may

be able to access. If desktop computers are provided, they are suggested to be located so the patient cannot easily reach them.

8. Electrical

a. Light Fixtures – Dimmable wall or ceiling washing light fixtures are suggested so that lower levels (and possibly more soothing color temperatures) are available to provide a less stimulating environment. See Baseline

9. Communications

a. Telephone Sets – are suggested to be cordless phones to reduce the number of wires that may be available to patients. If standard telephones are provided, it is suggested that they be located as far away from patients as possible or in lockable cabinets.

#650f

b. Nurse Calls / Duress Alarms If a personal duress alarm system[650] is not present, an emergency call button[654] for use by staff is strongly suggested to be provided so staff may summon additional staff members if necessary.

10. Electronic Safety

a. Metal Detectors[660] – may be provided in the Admissions area to assist with screening incoming patients for contraband. See Baseline


#654

Level V-b. Seclusion Suites and Restraint Suites

All items shall be the same as Level IV with the following exceptions:

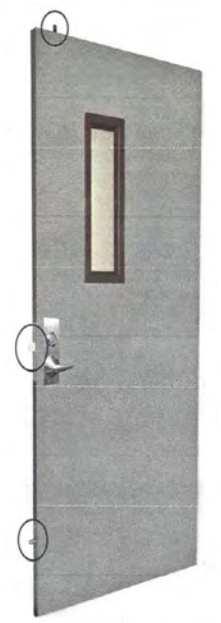
Seclusion Rooms and Restraint Rooms are very similar in design and construction with the size and furniture being the two main differentiating features. The ***FGI Guidelines*** require Seclusion Rooms to be a minimum of 60 square feet in floor area and Restraint rooms to be a minimum of 80 square feet in floor area. They should be no less than 7 feet wide and no greater than 11 feet long to avoid providing enough space for a patient to get a running start at the opposite wall. They should be designed to minimize blind spots where patients cannot be observed by staff without entering the room and outside corners are to be avoided, where possible. A minimum ceiling height of 9 feet is preferred.

It is strongly suggested that one room not be used for both secluding and restraining patients unless the loops for attaching the restraint straps are removed before the room is used for secluding a patient. The Safety Risk Assessment should address all aspects of seclusion and restraint in detail.

The distance of the seclusion room from the nurse station needs to be considered. The goal is to avoid excessive distance so staff can be readily available as needed. The seclusion room door should swing out of the room and open directly into an anteroom to separate these activities from other patients and give the patient access to a toilet without entering the corridor

1. Openings

a. Doors - Heavy-duty, commercial-grade steel doors with a minimum clear width of 3'-8" (usually requires nominal 4'-0" wide doors) that are hinged to swing out of the room. A polycarbonate[201] view window that does not exceed 100 square inches is strongly suggested to allow staff to observe the patient and determine the location of the patient before opening the door. The height of the window should allow shorter staff members to see into the room.



#160d

b. Door Hardware:

i. **Exposed door hardware** is typically not provided on the inside face of these doors.

ii. **The seclusion room door i**s preferred to have three-point latching with *manual activation of a single lever* required to engage all three bolts.[160] This operation greatly reduces the risk of a staff becoming locked in the room with a patient. Hardware that automatically latches when the door is closed and latched can result in staff being locked in the room with the patient.

c. Windows:

i. **Exterior** – If exterior windows are present, they are suggested to be a minimum of ½" thick polycarbonate and have either mini-blinds or roller blinds that have motorized operation controllable from the Ante Room.

ii. **Interior** – See comments on view window in the door above. Other interior windows in these rooms are discouraged to help avoid over-stimulation of patients.

#270a

2. Finishes

a. Walls:

i. **Padded wall finish** is often provided which has either a Kevlar-facing or heavy vinyl facing and 1 1/2" thick foam backing.[270]

ii. **Unpadded** - Impact-resistant gypsum board[230] over 3/4" plywood (or 25 gauge sheet metal which stiffens the wall, is easily cut and does not require wider door frames) on minimum 20-gauge metal studs at 16" on center with high performance finish[280] are minimum recommendations.

b. Ceilings – Impact-resistant and/or abrasion-resistant gypsum board[230, 231] painted with high performance finish[280] at 9'-0" minimum height is preferred.

c. Wall Base:

i. **Unpadded –** Use of a separate base material is not recommended in these rooms. If painted, exposed gypsum board finish is provided; it is preferred that it be extended to the floor and a pick-resistant caulk joint be provided at the floor. A painted stripe that is 4" or 6" high may be provided to help hide scuffing and marking on the wall.

ii. **Padded** – No base is typically provided, the padding extends to the top of the flooring.

d. Flooring – Provide continuous sheet vinyl with foam backing and heat-welded seams[272] or padded flooring to match wall padding.

3. Specialties

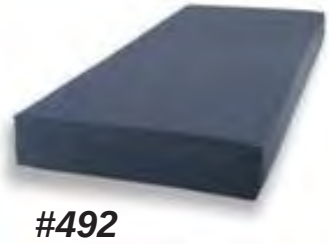
a. Mirrors and Domes – Observation Mirror – Install a convex mirror[420] at the ceiling in the corner of the room opposite the seclusion room door. Make sure the mirror can be seen when viewing it from the window in the door. This mirror will give staff a full view of the room prior to opening the door. Care shall be taken to assure the attachment is secure so the patient cannot remove it and have a weapon and the perimeter is sealed with pick-resistant caulk.

4. Furnishings

No furniture is typically provided in Seclusion rooms and Restraint Rooms other than the following:

a. Furniture:

i. **Seclusion rooms** are suggested to have only a behavioral health care mattress[492] on the floor or a special seclusion room bed.[493a] These beds should not have



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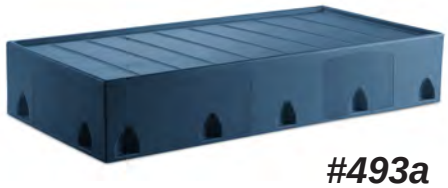
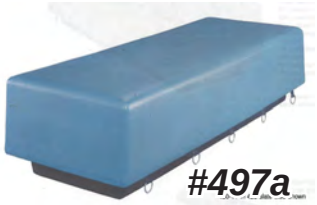


#493a

exposed loops to which mechanical restraints may be attached because these may be used as ligature attachment points for secluded patients.



#497a

ii. **Restraint rooms** are suggested to have special beds with loops for attachment of restraint straps.[497] These beds are typically anchored in place and positioned to allow space for access on at least three sides, if not all four sides.

iii. **Seclusion and Restraint Room** - If a room will be used for patients that are both in restraints and in seclusion (without restraints), there are several beds available that have restraint attachment loops that may be quickly and easily removed.[498]

#498a

5. Fire Suppression

a. **Fire Sprinkler Heads -** Institutional Type – Same as for Level IV.

6. Plumbing Fixtures and Fittings

a. **Same as those in Level IV-B** except that toilet fixtures of Powder-coated stainless-steel fixtures[534] or solid surface material[533] are preferred by some facilities.

NOTE: All plumbing fixtures intended for use by patients in this area are required by the FGI Guidelines to be in a separate room that is accessed via an Ante Room from the Seclusion/Restraint Room.

7. HVAC

a. **Diffusers, Registers and Grilles HVAC grilles -** Fully recessed, vandal-resistant grilles with S-shaped air passageways[600]

b. **Thermostats –** These are preferred to be a digital type with control mounted on the wall in the anteroom and sensor in the return air duct serving the room.

8. Electrical

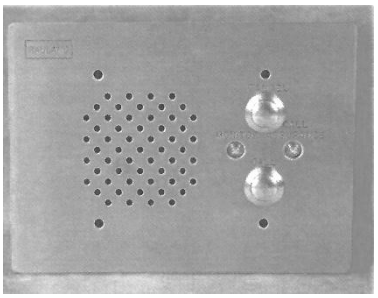
a. Electrical Devices. No electrical outlets, switches, thermostats, blank cover plates, or similar devices are permitted by the FGI Guidelines inside seclusion rooms.

b. Light Fixtures. Light Fixtures – Fully recessed, moisture-resistant, vandal-resistant light fixtures[620i] installed in the ceiling are recommended. Dimmable wall or ceiling washing light fixtures are suggested so that lower levels (and possibly more soothing colors) are available to provide a less stimulating environment.

9. Communications

a. Telephone Sets - None allowed.

b. Nurse Calls / Duress Alarms – None allowed, it is typical that a staff member is assigned to continuously observe the patient in these rooms. A staff assist call button[653] mounted in the Anteroom may be required by the FGI Guidelines



#653

Summary

Thoughtful consideration of these design elements and materials by design team members and hospital staff can result in a very aesthetically pleasing environment that will enhance the treatment process and help maximize safety for patients, staff, and visitors. It is strongly recommended that wall-hung lavatories, 2'x4' fluorescent light fixtures, paddle-handle door hardware, and many other items typically found in general hospitals **NOT** be used in behavioral health facilities. The reasons these are used in general hospitals typically do not exist in behavioral health care units. Their elimination will significantly reduce the institutional character of behavioral health facilities without decreasing patient or staff safety.

As stated in the introduction, this document is intended to represent leading current practices and does not establish minimum standards for behavioral health facilities or represent requirements of codes or regulatory agencies. No product or built environment is entirely without risk.

The authors' desire is that hospital staff and their design teams will use this information to start conversations about what is the best solution for each individual facility's patients and staff.

The Baseline level of concern in *Section A* is intended to represent a typical level of risk tolerance for inpatient units. This baseline is adjusted up or down for the levels of concern in the environmental safety risk assessment matrix as discussed herein.

Appendix Index

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

01 00 00 – General

01 00 01 – Trash Receptacle Liner

1a. Trash receptacle liner – paper
Sani-liner®
Wisconsin Converting
Green Bay, WI
920-593-8297
www.wisconsinconverting.com


#1a

1c. Trash receptacle liner – paper
Psych-Select-Bag™
Dano Group
Stamford, CT
800-348-3266
www.danoinc.com


#1c

07 00 00 – Thermal and Moisture Protection

07 92 00 – Joint Sealants

10a. Sound and Smoke Seals – Breakaway
Cush'N'Seal w/breakaway anti-ligature option
Door and Hardware Systems, Inc.
Rochester, NY
585-235-8543
www.dhsi-seal.com

#10a

10b. Sound and smoke seals – breakaway
Ligature-resistant Zag option
Zero International – Allegion
Indianapolis, IN
877-671-7011
www.zerointernational.com

10c. Sound and smoke/fire seals – breakaway
Adhesive gaskets - perforated
Pemko Manufacturing Company
Memphis, TN
800-824-3018
www.pemko.com


#10b

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

20a. Pick-resistant caulk
DynaflexTM SC
Pecora Corporation
Harleysville, PA
800-523-6688
www.pecora.com

20b. Pick-resistant caulk
Everseal # SB-190
Surebond
St. Charles. IL 60174
877-843-1818
www.surebond.com


#20b

20c. Pick-resistant caulk
MasterSeal® #CR 190
BASF Construction Chemicals
Shakopee, MN 55379
800-243-6739
www.master-builders-solutions.basf.us

08 00 00 - OPENINGS

08 10 00 – Doors and Frames

25a. Synthetic faced door
Acrovyn® Doors
Construction Specialties
Lebanon, NJ 08833
800-972-7214
www.c-sgroup.com


#25a

25b. Synthetic-faced door-
Thermal-Fused Doors
ASSA ABLOY Door Group
c/o Maiman
Springfield. MO 65803
417-616-8234
www.assaabloywooddoors.com


#25b

08 31 13 – Access Doors

30.a Access panel – lockable

SP Steel Security Panel with mortise deadbolt prep

J. L. Industries, Inc.
Bloomington, MN 55435
800-554-6077
www.jlindustries.com

30.b Access panel – lockable

Security Access Panel with tamper resistant latches & rounded corners

Weizel Security
800-308-3627
www.securinghospitals.com

08 34 00 – Special Function Doors

40a. Patient toilet door

Wanford En-Suite Bathroom Door

Safehinge-Primera
UK
0330-058-0988
www.safehingeprimera.com

40b. Patient toilet door

En-Suite Patient Bathroom Door w/ Shower Door Option: #SHDUS02

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com
NOTE: Hinge only, see Item 111g; Rubber fin only, see item 473e

40c. Patient Toilet Door

Ligature Resistant Sliding Door System with Frame

Accurate Lock and Hardware
Stamford, CT 06902
203-348-8865
www.accuratelockandhardware.com


#40c

40d. Patient toilet door

Sentinel Event Reduction Door

Norva Plastics, Inc.
Norfolk, VA 23508
800-826-0758
www.norvaplastics.com


#40d

40e. Patient toilet door

Soft Suicide Prevention Door

Kennon Products, Inc.
Sheridan, WY 82801
307-674-6498
www.suicideproofing.com


#40e

40f. Patient toilet door

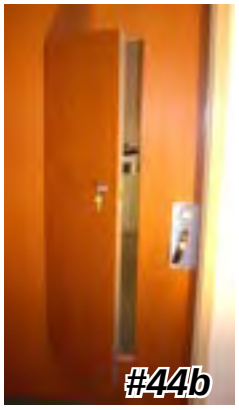
SafeDoor

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

44b. Wicket doors

Acrovyn® Barrier-Resistant Doors

Construction Specialties
Lebanon, NJ 08833
800-972-7214
www.c-sgroup.com


#44b

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

44c. Wicket doors

Behavioral Health Series Patient Room Access Door

ASSA ABLOY Door Security Solutions
New Haven, CT 06511
800-377-3948
www.assaabloydss.com


#44c

44d. Wicket doors

Wicket Door (Wood Doors)

Marshfield Door Systems
Marshfield, WI 54449
800-869-3667
www.marshfielddoors.com

44e. Wicket doors

GCD-EC Flush Wicket Door with structural composite lumber core

Graham Wood Door
Mason City, Iowa 50401
641-423-2444
www.grahamdoors.com


#47a

47a. Security sidelight

Security Sidelite Unit

Curries Company
Mason City, IA 50401
641-423-1334
www.curries.com

47b. Security sidelight

Security SideLite Unit

Ceco Door
Milan, TN 38358
www.cecodoor.com


#47b

08 51 13 – Aluminum Windows

60a. Aluminum window with integral blind

2450 Series Storefront with hinged sash and integral blind

Manko Window Systems, Inc.
Manhattan, KS 66502
800-642-1488
www.mankowindows.com

#60a

60b. Aluminum window with integral blind

2187-DT Psychiatric Windows with integral blind

Wausau Window and Wall Systems
Wausau, WI 54401
877-678-2983
www.wausauwindow.com

#60b

60c. Aluminum window with integral blind - removable

SS-5100 Medium-Security Mental Health Security Window

Sherwood Windows Group
Toronto, Ontario M9W 5E3
Canada
800-770-5256
www.sherwoodwindows.com

#61a

61a. Exterior windows - ventilation

Safevent Windows

Britplas
Woolston, Warrington WA1 4RW
England
+44-1925-824317
www.britplas.com

61b. Exterior windows - ventilation

SW-6300 Operable Security Window

Sherwood Windows Group
Toronto, Ontario M9W 5E3
Canada
800-770-5256
www.sherwoodwindows.com

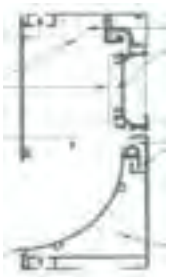
#61b

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

61c. Exterior windows - ventilation

512 Ventrow Ventilator

Kawneer North America
Norcross, GA 30092
770-449-5555
www.kawneer.com



08 56 56 – Security Window Screens

80. Security screens

Security Screens

Kane Innovations
Erie, PA 16506
800-773-2439
www.kanescreens.com

#80

08 71 00 – Door Hardware

100a. Door closer

Concealed closer #2010 Series

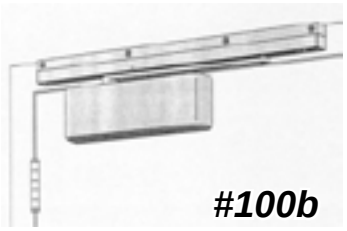
LCN
Princeton, IL 61356-0100
877-671-7011
us.allegion.com/brands/lcn/Pages/default.aspx

#100a

100b. Door closer

High-security track closer #4510T SMOOTHEE® Series

LCN
121 West Railroad Avenue
Princeton, IL 61356-0100
877-671-7011
us.allegion.com/brands/lcn/Pages/default.aspx



#100b

101. Electrically controlled door closer

Fire/Life Safety Series HSA Sentronic Electrically Controlled Closer/Holder

LCN
P.O. Box 100
Princeton, IL. 61356-0100
815-875-3111
us.allegion.com/brands/lcn/Pages/default.aspx

#101

109. Electric-release concealed deadbolts

ELECTRATM concealed vertical rod latching lever locksets

Securitech Group, Inc.
Maspeth, NY 11378
800-622-5625
www.securitech.com

#110

110. Electromagnetic lock

Electromagnetic Locks

DynaLock Corporation
Bristol, CT 06010
877-396-2562
www.dynalock.com

#111a

111a. Continuous hinges – gear type with hospital tip

780-Series Roton Hinges

Hager Companies
St. Louis, MO 63104
800-325-9995
www.hagerco.com/Product-Listing.aspx?CatID=152&SubCatID=189

111b. Continuous hinges – gear type with hospital tip

112HD Concealed Continuous Hinge

Ives
Indianapolis, IN 46219
877-671-7011
us.allegion.com

#111b

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

111c. Continuous hinges – gear type with hospital tip

825-S22 SR™SR824-S22 SafeSupport Continuous Gear Hinge

Weizel Security
800-308-3627
www.securinghospitals.com

111e. Continuous hinges – gear type with hospital tip

Continuous Geared Hinge # KG200

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#111e

111f. Continuous Hinges – gear type with hospital tip

SL11 Concealed single acting continuous geared hinge

Select Products Limited
Portage MI 49024
800-423-1174
www.selecthinges.com

#111f

111g. Continuous hinges

Anti-Ligature Continuous Swing Hinge for Shower w/ Cap# KG203

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

113a. Double-acting continuous hinge

Double Swing Hinge #DSH1000 Barrel Type

Markar
Memphis, TN 38181
www.assaabloydooraccessories.us/en/local/assaabloydooraccessoriesus/products/hinges/continuous-pin-barrel-hinges/behavioral-health-hinges/

#113a

113c. Double-acting continuous hinge

Swing Hinge # KG202

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

113d. Double-acting continuous hinge

Switch Hinge # KG280

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

115b. Emergency stop

Emergency Release Stop #ERS

Pemko Manufacturing Company
Memphis, TN 38141
800-824-3018
www.pemko.com

#115b

#115b

115c. Emergency stop

Swing Stop # KG205, KG206

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

120. Door pull

Vandal-Resistant Door Pull Trim # VR910-DT

Ives
Indianapolis, IN 46219
877-671-7011
us.allegion.com

121c. Door pull, recessed

Heavy Duty Security Flush Pull # D89

Rockwood Manufacturing Company
Rockwood, PA 15557
800-458-2424
www.rockwoodmfg.com

#121c

121d. Door pull, recessed

Heavy Duty ADA Security Flush Pull # BF97L

Rockwood Manufacturing Company
Rockwood, PA 15557
800-458-2424
www.rockwoodmfg.com

#121d

130a. Ligature-resistant lever handle lockset

Anti Ligature Lockset (Mortise and Cylindrical) #SPSL

Best Access Systems
Indianapolis, IN 46250
317-849-2250
www.bestaccess.com/index.php/products/behavioral-health-products/

#130a

130b. Ligature-resistant lever handle lockset

Schlage L Series Extra Heavy Duty Mortise Lock with ligature resistant lever

Allegion
877-671-7011
us.allegion.com/IRSTDocs/Brochure/106510.pdf

#130b

130c. Ligature-resistant lever handle lockset

Series 5SS19 Institutional Life Safety Mortise Locksets - Levers

Marks USA
Amityville, NY 11701
800-526-0233
www.marksusa.com

#130c

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130d. Ligature-resistant lever handle lockset

LSL Life Safety Lever Series

Grainger
Lake Forest, IL 60045
800-472-4643
www.grainger.com

131a. Ligature-resistant modified lever handle lockset

8200 with BHW Trim

Sargent Manufacturing Company
100 Sargent Drive
New Haven, CT 06536-0915
800-727-5477
www.sargentlock.com

131b. Ligature-resistant modified lever handle lockset

Crescent Handle – horizontal installation

Accurate Lock and Hardware
Stamford, CT 06902
203-348-8865
www.accuratelockandhardware.com

131c. Ligature-resistant modified lever handle lockset

Securitech; Solis handle available for both mortise and cylindrical locksets)

Securitech Group, Inc.
Maspeth, NY 11378
800-622-5625
www.securitech.com/securiguard/

131d. Ligature-resistant modified lever handle lockset

HD Ligature Resistant Cylindrical Lock CH-CYL Series

Accurate Lock and Hardware
Stamford, CT 06902
203-348-8865
www.accuratelockandhardware.com

132a. Ligature-resistant lockset

Ligature Resistant Push/Pull 9125ALP

Accurate Lock and Hardware
Stamford, CT 06902
203-348-8865
www.accuratelockandhardware.com

#132a

140. Patient room privacy lockset

Patient Room Privacy Lockset

Best Access Systems
Indianapolis, IN 46250
800-392-5209
www.bestaccess.com/products/behavioral-health-products/

141a. Cylinder protector

Securiguard Cylinder Protector; Model #63LR

Securitech Group, Inc.
Maspeth, NY 11378
800-622-5625
www.securitech.com/securiguard/

141b. Cylinder protector

ShieldX Cylinder Protector

Grainger
Lake Forest, IL 60045
800-472-4643
www.grainger.com

143a. Deadbolt

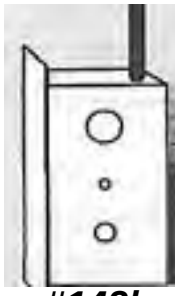
Deadbolt with ligature-resistant turn piece (retract bolt only) #PBL102-630

Securitech Group, Inc.
Maspeth, NY 11378
800-622-5625
www.securitech.com

143b. Deadbolt

Vertical Deadbolt with ligature-resist. turn piece (retract bolt only) #52XXV-F17

Securitech Group, Inc.
Maspeth, NY 11378
800-622-5625
www.securitech.com



144. Sallyport interlock hardware

RACHIE™ series lockset package

Securitech Group, Inc.
Maspeth, NY 11378
800-622-5625
www.securitech.com

145. Remote authorization

Assa Cliq Remote Authorization System

Assa Abloy
www.assaboly.com

146. Ball catch
Dual Adjustable Ball Catch #347
Ives
Indianapolis, IN 46219
877-671-7011
us.allegion.com


#146

147. Roller latch
Roller Latch # RL30
Ives
Indianapolis, IN 46219
877-671-7011
us.allegion.com


#147

148. Magnetic latch
Super-Mite Heavy Duty Magnetic Catch #327
Ives
Indianapolis, IN 46219
877-671-7011
us.allegion.com


#148

150a. Over-door alarm
The Door Switch
St. Louis, MO 63146
877-998-5625
thedoorswitch.com


#150a

150b. Over-door alarm
Top Door Alarm®
Door Control Services, Inc.
Ben Wheeler, TX 75754
800-356-2025
www.doorcontrolservices.com

#150b

150c. Over-door alarm

SEDA Door Alarm

Best Access Solutions, Inc.
Indianapolis, IN 46250
www.bestaccess.com/products/behavioral-health-products/

150d. Over-door alarm

LISA-Kit (Life Safety Alarm)

Grainger
Lake Forest, IL 60045
800-472-4643
www.grainger.com

150d. Over-door alarm

DAISY – Over-the-Door Alarm)

Securitech Group, Inc.
Maspeth, NY 11378
800-622-5625
www.securitech.com

160a. Seclusion room door locks

Seclusion Room Lock (surface mount)

Securitech
Maspeth, NY 11378
800-622-5625
www.securitech.com

160b. Seclusion room door locks

Multi-Point Deadbolt Mortise Lock - UML Series (concealed mount)

Securitech
Maspeth, NY 11378
800-622-5625
www.securitech.com

160c. Seclusion room door locks

Schlage; Multipoint Solution # LM9300

Ingersoll Rand Security Technologies
Carmel, IN 46032 US
877-671-7011
us.allegion.com/IRSTDocuments1/104833.pdf

#160c

160d. Seclusion room door locks

Multi-Bolt Self-Latching Concealed Locksets (USL Series)

Securitech
Maspeth, NY 11378
800-622-5625
www.securitech.com

#160d

161. Cross-corridor door locks

Electra Concealed Vertical Rod Latching Lever Locksets #109

Securitech
Maspeth, NY 11378
800-622-5625
www.securitech.com

#161

162. Elopement buffer or sallyport door locks

RACHIE Entry & Exit Control Systems

Securitech
Maspeth, NY 11378
800-622-5625
www.securitech.com

#162

175a. Wall Stops

KG184 Anti-Ligature Rubber Wall Stop

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#175a

175b. Wall Stops

KG270-278 Anti-Ligature Extended Rubber Wall Stop

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com


#175b

08 87 53 – Security Films

190a. Window film

Scotchshield™ – 14 mil Film with Perimeter Attachment System

3M Specified Construction Products Department
St. Paul, MN 55144
888-364-3577
www.3m.com

190b. Window film

200 Series – Safety and Security Laminate

ACE (Advanced Coatings Engineering)
Newark, DE 19713
888-607-0000
www.usace.com

08 88 53 – Security Glazing

200a. Security glazing

121000 or 121100 ArmorProtect Plus®

Oldcastle Building Envelope®
Dallas, TX 75244
866-653-2278
www.obe.com

200b. Security glazing

9/16Psych-2118

Global Security Glazing
Selma, AL 36703
(800) 633-2513
www.security-glazing.com

(NOTE: meets ASTM F1233 Class 1.4)


#200b

200c. Security glazing

Laminated Annealed Glass w/ SGP Interlayer

Global Security Glazing
Selma, AL 36703
(800) 633-2513
www.security-glazing.com

201a. Polycarbonate sheet glazing – abrasion-resistant

MR10 LEXAN - MARGARD II Sheet

SABIC Americas
Pittsfield, MA 01201
800-323-3783
www.sabic.com

201b. Polycarbonate sheet glazing

Makrolon® GP Sheet

Covestro LLC
Pittsburgh, PA 15205-9723
877-229-3778
www.sheets.covestro.com

205a. Fire-rated glazing

Fireglass; FireLite ®

Technical Glass Products (TGP) (Allegion)
800-426-0279
www.fireglass.com

205b. Fire-rated glazing

Fireglass; WireLite ® - NT

Technical Glass Products (TGP) (Allegion)
800-426-0279
www.fireglass.com

220a. Vision panels

Vision panels, key operation

VISTAMATIC®
Coral Springs, FL 33065
866-466-9525
www.vistamaticvisionpanels.com


#220a

220b. Vision panels

Duralux Secure Privacy Vision Panel

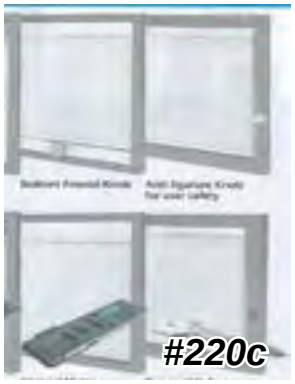
Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com


#220b

220c. Vision panels

ViuLite manual or motorized blinds inside glass panels

Unicel Architectural Corp.
Longueuil, Quebec, Canada J4G 2J4
800-668-1580
www.unicelarchitectural.com


#220c

220d. Vision panels

Between Glass Blinds vision panels

VISTAMATIC, LLC
Coral Springs, FL 33065
866-466-9525
www.betweenglassblinds.com


#220d

220e. Vision panels

IE; Blinds® sealed, integral blind assemblies

IE Blinds
Ben Wheeler, TX 75754
866-267-1917
www.ieblinds.com

221a. Vision panels

Clarity Privacy Glass (electric)

VISTAMATIC®
Coral Springs, FL 33065
866-466-9525
www.vistamaticvisionpanels.com

221b. Vision Panels

Duralux Platinum Switchable Vision Panel (electric)

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

09 00 00 – Finishes

09 21 16 – Gypsum Board

230a. Impact-resistant gypsum board

Sheetrock® Brand engineered gypsum panels – abuse-resistant

USG Corporation
Chicago, IL 60661
800-874-4968
www.usg.com

230b. Impact-resistant wallboard

Gold Bond® Brand Hi-Impact® XP® Gypsum Board – moisture- and fire-resistant also has abrasion resistant paper face

National Gypsum Company
Charlotte, NC 28211
704-365-7300
www.nationalgypsum.com

230c. Impact-resistant wallboard

Extreme Impact Resistant Type X Gypsum Board

CertainTeed Corporation
Melvern, PA 19355
800-233-8990
www.certainteed.com

231a. Abrasion-resistant wallboard

Gold Bond® Brand Hi-Abuse® XP® Gypsum Board

National Gypsum Company
Charlotte, NC 28211
704-365-7300
www.nationalgypsum.com

231b. Abrasion-resistant wallboard

Extreme Abuse Resistant Type X Gypsum Board

CertainTeed Corporation
Melvern, PA 19355
800-233-8990
www.certainteed.com

232a. Sound-absorbing wallboard

QuietRock sound-reducing panels

PABCO® Gypsum
Newark, CA 94560
800-797-8159
www.quietrock.com

232b. Sound-absorbing wallboard

Silent FX Quick Cut Noise Reducing Type X Gypsum Board

CertainTeed Corporation
Melvern, PA 19355
800-233-8990
www.certainteed.com

232c. Sound Attenuation wallboard

Gold Bond® Soundboard® XP® Gypsum Board

National Gypsum Company
Charlotte, NC 28211
704-365-7300
www.nationalgypsum.com

09 50 00 – Ceilings

234a. Ceiling Accessories

MBAC – Main Beam Adapter Clip for attaching gyp. bd. to ceiling grid

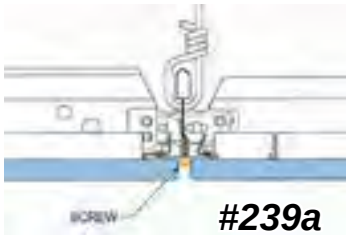
Armstrong Ceiling Solutions
www.armstrongceilings.com

#234a

239a. Tamper-resistant ceiling panels

Metal Works; Vector

Armstrong Ceiling Solutions
877-276-7876
www.armstrongceilings.com

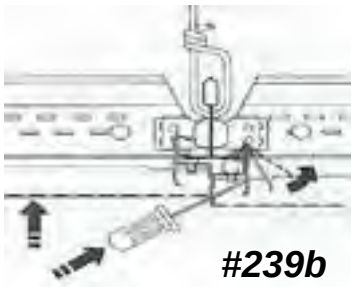


#239a

239b. Tamper-resistant ceiling panels

Metal Works; Clip-On

Armstrong Ceiling Solutions
877-276-7876
www.armstrongceilings.com



#239b

09 65 13 – Resilient Base

240. Wall base

Health Design™ Wall Base

FLEXCO® Corporation
Tuscumbia. AL 35674
800-633-3151
www.flexcofloors.com

241a. Wall base

Visuelle Wall Base

Roppe Corporation, USA
Fostoria, OH 44830
800-537-9527
www.roppe.com

241b. Wall base

Johnsonite "Millwork" Contours Wall Base – PV4065

Tarkett
30000 Aurora Road
Solon, OH 44139
800-899-8916
www.tarkettna.com

09 65 16 – Resilient Flooring

245a. Sheet vinyl flooring

Homogeneous Vinyl Sheet Flooring

Armstrong Flooring, Inc.
Lancaster, PA 17604
888-276-7876
www.armstrong.com

245b. Sheet vinyl flooring

Noraplan sheet flooring

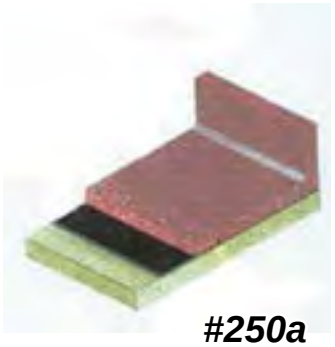
nora® systems, Inc.
Salem, NH 03079
800-332-NORA
www.nora.com/us

09 67 00 – Fluid-Applied Flooring

250a. Seamless floors and base

Cheminert K flooring

Dex-O-Tex
Division of Crossfield Products Corp.
Roselle Park, NJ 07204
908-245-2800
www.dexotex.com



250b. Seamless floors and base

Seamless flooring systems
Dur-A-Flex, Inc.
East Hartford, CT 06108
877-2 51-5418
www.dur-a-flex.com

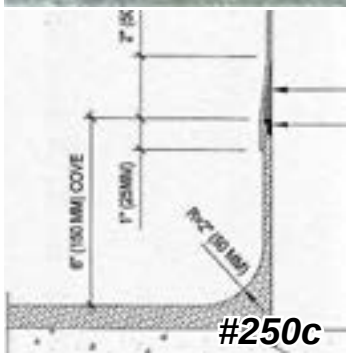

#250b

250c. Seamless floors and base
Sika Corp.; Sikafloor – no top edge trim at integral base
Sika Corporation
Lyndhurst, NJ 07071
800-933-7452
www.sikafloorusa.com


#250c

09 68 16 – Sheet Carpeting

255. Carpet
Mohawk Group GL 182 Exotic Fauna Sheet Carpet with Unibond Plus Bloc backing
Mohawk Group
Calhoun, GA 30701
800-554-6637
www.Mohawkgroup.com



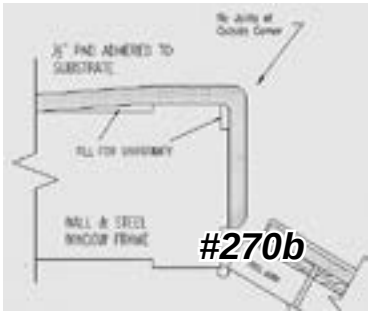
#250c

09 77 00 – Special Wall Surfacing

270a. Wall padding
Gold Medal Safety Padding®
Marathon Engineering Corporation
Lehigh Acres, FL 33913
239-303-7378
goldmedalsafetypadding.com


#270a

270b. Wall padding
Surface padding systems
Padded Surfaces by B&E
Indianapolis, IN 46241
888-243-8788
paddedsurfaces.com


#270b

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

272. Seclusion room wall and floor material

Lonfloor Plain – smooth

Lonseal, Inc.
Carson, CA 90745
800-832-7111
www.lonseal.com

09 96 13 – Abrasion Resistant Coatings

280. Wall finish (do not use on floors)

Sto; Decocoat®

Sto Americas
Building 1400, Suite 120
Atlanta, GA 30331
800-221-2397
www.stocorp.com

10 00 00 – SPECIALTIES

10 12 00 – Display Cases

290a. TV enclosure – suicide-resistant

TE450 Ligature-Resistant Protective TV Enclosure

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#290a

290b. TV Enclosure – suicide resistant

Protective Enclosures, FPE55F(H)-S

Peerless A-V
Aurora, IL 60502
800-865-2112
www.perlessmounts.com

#290b

290c. TV enclosure – suicide-resistant

Ligature-resistant TV enclosure

ProEnc
Jersey City, NJ 07302
862-234-5981
www.lcdtvenclosure.com


#290c

10 14 00 – Signage

300a. Room signs

FIxsigns

2/90 Sign Systems
Grand Rapids, MI 49512
800-777-4310
www.290signs.com

#300a

300b. Room signs

Secure + spec

Creative Signage Systems, Inc.
College Park, MD 20740
800-220-7446
www.creativesignage.com

#300b

300c. Room signs

KING KMS® Modular Sign System

King Architectural Products
Bolton, ON, Canada, L7E 2R6
877-857-2804
www.kingarchitecturalproducts.com

#300c

300d. Room signs

Safecare Signs

2/90 Sign Systems
Grand Rapids, MI 49512
800-777-4310
www.290signs.com

#300d

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10 26 16.16 – Protective Corridor Handrails

310a. Corridor handrail

Acrovyn® ligature-resistant handrail with continuous aluminum mounting bracket

Construction Specialties
Muncy, PA 17756
800-233-8493
www.c-sgroup.com

#310a

10 26 23 – Protective Wall Covering

320a. Synthetic wall protection

Avonite® Acrylic products - Wall Protection

Avonite
Belen, NM 87002
800-4-AVONITE
www.avonitesurfaces.com

320b. Synthetic wall protection

Acrovyn by Design® Wall Protection

Construction Specialties
Muncy, PA 17756
800-233-8493
www.c-sgroup.com

#320

320c. Synthetic wall protection

Ricochet Flexible Wall Protection

Inpro Corporation
Muskego, WI 53150
800-222-5556
inprocorp.com

#320c

10 28 13 – Security Toilet Accessories

332a. Grab bar

Anti-Ligature Grab Bar KG270-278

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#332a

332b. Grab bar

Ligature - Resistant Grab Bar #GB730

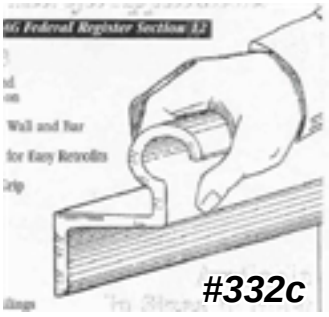
Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#332b

332c. Grab bar

SAFEBAR® grab bar

Cascade Specialty Hardware, Inc.
Vancouver, WA 98660
360-823-3995
www.cascadesh.com



#332c

332d. Grab bar

SafeSupport® Safe-T Grab Bar #811-S01

Weizel Security
800-308-3627
www.securinghospitals.com

#332d

332e. Grab bar

NW SecurityBar®

Northwest Specialty Hardware, Inc.
Clackamas, OR 97015
503-557-1881
www.northwestsh.com

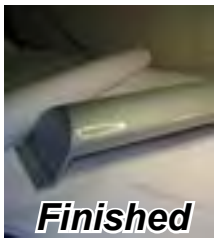
#332e

337. Grab bar – vertical

SP-3V Vertical Grab Bar

Odd Ball Industries
Greenlawn, NY 11740
631-754-0400
www.oddballindustries.com

Cross Section #337



Finished End #337

340. Paper towel dispenser

Paper Towel Dispenser Cover #817-S45 SR™

Weizel Security
800-308-3627
www.securinghospitals.com

#340

340b. Paper towel dispenser

Paper Towel Dispenser # KG02

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#340b

340c. Paper Towel Dispenser

Ligature - Resistant Paper Towel Dispenser #PH240

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#340c

341. Roll Paper Towel Dispenser

Roll Paper Towel Dispenser #WH1848B

Whitehall Manufacturing
City of Industry, CA 91744
1-800-782-7706
www.whitehallmfg.com

#341

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

350a. Robe hook – break-away

Robe/Towel Hook # SP6

Odd Ball Industries Mfg. Co., Inc.
Greenlawn, NY 11740
1-631-754-0400
www.oddballindustries.com

350b. Robe hook – break-away

SafeSupport SR Collapsible Towel Hook # SR813-S08

Weizel Security
800-308-3627
www.securinghospitals.com

350d. Robe hook – break-away

Clothes Hook #NW 608

Northwest Specialty Hardware, Inc.
Clackamas, OR 97015
503-557-1881
www.northwestsh.com

350e. Robe hook – breakaway

Coat Hook # KG180

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

360a. Security Mirrors

Hybrid Safety Mirror in Guardian Frame

RAO Contract Sales, Inc.
392 Atwood Place
Wyckoff, NJ 07481
800-445-7065
www.rao.com

360b. Security Mirrors

ROVAL™ stainless steel mirror #20650-B

American Specialties, Inc.
Yonkers, NY 10701
914-476-9000
www.americanspecialties.com

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

360c. Security Mirrors

Security mirror #JOC-161

McGrory Glass, Inc.
Paulsboro, NJ 08066
856-579-3200
www.mcgrory-glass.com

360d. Security Mirrors

Sole - Illuminated Mirror for High Abuse Applications

Visa Lighting
Milwaukee, WI 53209
800-788-84272
www.visalighting.com


#360d

361a. Mirror guard

Mirror Guard # SP-8

Odd Ball Industries
Greenlawn, NY 11740
631-754-0400
www.oddballindustries.com


#361a

370a. Recessed shelf

Ligature-Resistant Recessed Shelf (front mount through flange) # RS780

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

370b. Recessed Shelf

Ligature-Resistant Recessed Shelf (front mount through flange) #KG12

Kingsway Group USA
2807 Samoset Road, Suite 200
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com


#370b

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

370c. Recessed shelf

BestCare® Recessed Shelf (front mount through flange) # WH1820FA

Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

#370c

370d. Recessed shelf

Recessed Shelf (front mount through side) # Model 412

American Specialties, Inc.
Yonkers, NY 10701
914-476-9000
www.americanspecialties.com


#370d

371c. Shelf – surface-mounted

Bookshelf # SA56

Bradley Corporation
Menomonee Falls, WI 53051
800-272-3539
www.bradleycorp.com


371c

380a. Shower seat

ADA Shower Seat

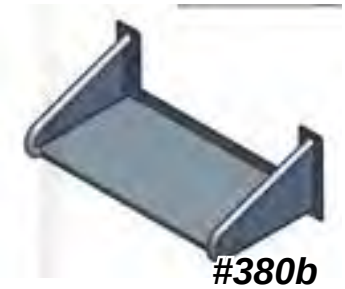
Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com


#380a

380b. Shower seat

ADA Shower Seat

Brey-Krause Manufacturing Co.
Bethlehem, PA 18018
610-867-1401
www.breykrause.com


#380b

390a. Soap Dish

Bestcare Bathroom Accessory Solutions #WH1832-PF (front mount with plaster flange)

Whitehall Manufacturing
City of Industry, CA 91744
1-800-782-7706
www.whitehallmfg.com

#390a

390b. Soap dish

Norix Group Inc.; Recessed Soap Dish (rear mount)

Norix Group, Inc.
West Chicago, IL 60185
1-800-234-4900
www.norix.com

#390b

391a. Soap dispenser

KG08 Manual Soap Dispenser – Gojo Compatible

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#391a

391b. Soap dispenser

ADX-12TM Security Enclosure

GOJO Industries, Inc.
Akron, OH 44309
800-321-9647
www.gojo.com

#391b

391c. Soap dispenser

Suicide Prevention Soap Dispenser

Norva Plastics, Inc.
Norfolk, VA 23508
800-826-0758
www.norvaplastics.com

#391c

391d. Soap dispenser

Ligature Resistant Soap Dispenser #SD750

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#391d

400a. Toilet paper holder

Toilet Roll Holder # KG13

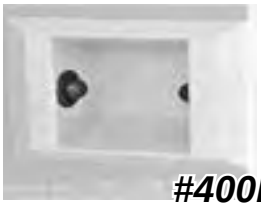
Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#400a

400b. Toilet paper holder

Toilet Roll Holder #WH1847B Series (Recessed model (1845B) also available)

Whitehall Manufacturing
City of Industry, CA 91744
1-800-782-7706
www.whitehallmfg.com



#400b

400c Toilet paper holder

Surface Mount Toilet Roll Holder # KG03

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com


#400c

400d Toilet paper holder

Ligature Resistant Toilet Paper Holder #TR740

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com


#400d

400f. Toilet paper holder

Safety Toilet Paper Holder #C-400

Cascade Specialty Hardware, Inc.
Vancouver, WA 98660
360-823-3995
www.cascadesh.com


#400f

400h. Toilet paper holder

Suicide-Resistant Toilet Paper Dispenser

Norva Plastics, Inc.
Norfolk, VA 23508
800-826-0758
www.norvaplastics.com


#400h

410a. Undersink protection

Truebro® Lav Shield®

IPS® Corporation
Compton, CA 90220
310-898-3300
www.truebro.com

410b. Undersink protection

Undersink Enclosure #831-S27 SRTM

Weizel Security
800-308-3627
www.securinghospitals.com


#410a

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10 86 00 – Security Mirrors and Domes

420a. Convex mirrors

DuraVision Quarter Dome Mirror

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com


#420a

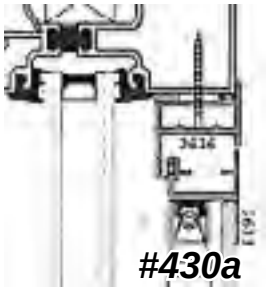
12 00 00 – FURNISHINGS

12 21 13 – Horizontal Louver Blinds

430a. Aluminum window with integral blind

Storefront with hinged sash and integral blind #2450 Series

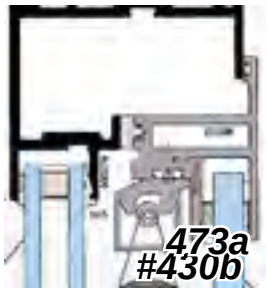
Manko Window Systems, Inc.
Manhattan, KS 66502
800-642-1488
www.mankowindows.com


#430a

430b. Aluminum window with integral blind

Psychiatric Windows with integral blind #2187-DT

Wausau Window and Wall Systems
Wausau, WI 54401
877-678-2983
www.wausauwindow.com


473a
#430b

430c. Aluminum window with integral blind - removable

Medium-Security Mental Health Security Window # SS-5100

Sherwood Windows Group
Toronto, Ontario M9W 5E3
Canada
800-770- 5256
www.sherwoodwindows.com


#430c

434a. Exterior windows - ventilation

Safevent Windows

Britplas
Woolston, Warrington WA1 4RW
England
+44-1925-824317
www.britplas.com


#434a

434b. Exterior windows - ventilation

Operable Security Window # SW-6300

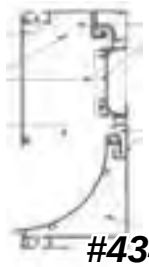
Sherwood Windows Group
Toronto, Ontario M9W 5E3
Canada
800-770-5256
www.sherwoodwindows.com


#434b

434c. Exterior windows - ventilation

512 Ventrow Ventilator

Kawneer North America
Norcross, GA 30092
770-449-5555
www.kawneer.com


#434c

12 21 33 – Roll-Down Blinds

440a. Roller blinds

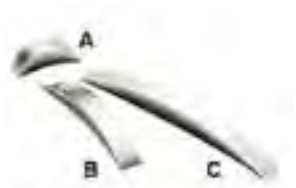
Webb Lok cordless roller shades

Inpro
Muskego, WI 53150
800-222-5556
https://www.inprocorp.com/clickeze-privacy-systems/specialty-window-shades


#440a

12 35 70 – Healthcare Case Work

460a. Cabinet pulls
Cabinet Pull # DP74C
Doug Mockett & Company, Inc.
Torrance, CA 90501
800-523-1269
www.mockett.com



#460a

460b. Cabinet pulls
Zinc Handle – polished chrome finish #104.66.200
Hafele America Co.
Archdale, NC 27263
800-423-3531
www.hafele.com/us/en


#460b

460c. Cabinet pulls
Arc Cabinet Pull #DP18
Doug Mockett & Company, Inc.
Torrance, CA 90501
800-523-1269
www.mockett.com


#460c

465a. Cabinet locks – keyless
eLock®: Cabinet version #300 Series
CompX Security Products
847-752-2500
www.compxelock.com


#465a

465b. Cabinet locks – keyless
dialock
Hafele America Co.
800-423-3531
www.hafele.com/us/en

465c. Cabinet locks – keyless
eLock: Cabinet Version #100 Series
CompX Security Products
Mauldin, SC 29662
864-297-6655
www.compxelock.com


#465b

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

470a. Tamper-resistant screws

Socket Security & Torx Security

Tamperproof Screw Company, Inc.
Hicksville, NY 11801
516-931-1616
www.tamperproof.com

#470a

470b. Tamper-resistant screws

Security Pin Torx Screws and Bits

Northwest Specialty Hardware, Inc.
Clackamas, OR 97015
503-557-1881
www.northwestsh.com

#470b

12 44 16 – Shower Doors

473a. Shower doors

Wanford ShowerDoor

Safehinge-Primera
UK
0330-058-0988
www.safehingeprimera.com

#470a

473b. Shower doors

En-Suite Patient Bathroom Door w/ Shower Door Option: #SHDUS02

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#473b

473c. Shower doors

Sentinel Event Reduction Shower Door

Norva Plastics, Inc.
Norfolk, VA 23508
800-826-0758
www.norvaplastics.com

473c

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

473d. Shower doors

Soft Suicide Prevention Door

Kennon Products, Inc.
Sheridan, WY 82801
307-674-6498
www.suicideproofing.com


#473d

473e. Shower door hinge

SwingHinge double action continuous hinge for SHOWER DOOR with surface cap and hinge cover plate # KG203

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com


#473e

473f. Shower door rubber fin

Shower System Rubber Fin and mounting Section with top fixing bracket #SRF01

Kingsway Group USA
Royal Oak, MI 48073
800-783-7980
www.kingswaygroupusa.com

#473f

12 46 23 – Decorative Crafts

475. Vinyl artwork

Soft Suicide Prevention Artwork (SSPA)

Kennon Products, Inc.
Sheridan, WY 82801
307-674-6498
www.suicideproofing.com


#475

476a. Ligature-resistant frames

Solid surface frames

Custom Design Frameworks
Mechanicsville, VA 23111
804-476-4233
www.customdesignframeworks.com


#476a

476b. Ligature-resistant frames

AF550 Ligature-Resistant Art Frame

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com


#476b

476c. Display boards

Tak-Les Bulletin Board with Guardian Frame

RAO Contract Sales, Inc.
Paterson, NJ 07501
800-445-7065
www.rao.com


#476c

12 52 70 – Healthcare Seating

479a.Stools

OFS Brands; Boost Ottoman

OFS Brands
Huntingburg, IN 47542
800-521-5381
info@ofsbrands.com


#479a

479b. Stools

Norix: Slammer Stool Series

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

480a. Sand-ballasted seating

Ultra-Max Series

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

480b. Sand-ballasted seating

Pineapple; Skye Plus ASKYP1-400

Pineapple Contracts
Clawson, MI 48017
800-496-9324
www.pineapplecontracts.com

480c. Sand-ballasted seating

Hardi Series Dining Chair #8701

Spec Furniture Inc.
Toronto, Ontario M9W 5B1
Canada
888-761-7732
www.specfurniture.com

481a. Lightweight seating

Integra Series chairs

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

481b. Lightweight seating
RazorBack Chair
Cortech® USA
Willowbrook, IL 60527
800-571-0770
www.cortechusa.com


#481b

481c. Lightweight seating
Stackable chair #5000-20 Modumaxx
Moduform
Fitchburg, MA 01420
800-221-6638
www.moduform.com


#482e

481d. Lightweight seating
Boden Series seating
Pineapple Contracts, Inc.
Clawson, MI 48017
800-496-9324
www.pineapplecontracts.com


#481d

482a. Upholstered seating
Sierra Series chairs with solid arms
Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com


#482a

482b. Upholstered seating
Meridian Behavioral Health Seating – chair # ML30/27BH
Nemschoff
Sheboygan, WI 53081
800-203-8916
www.nemschoff.com


#482g

#482b

482c. Upholstered seating
Wink Series Chair
Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com


#482c

482d. Upholstered seating
Endurance Series
Blockhouse Company, Inc.
York, PA 17406
800-346-1126
www.blockhouse.com

#482d

482e. Upholstered seating
Dignity Series #4501M
Spec Furniture Inc.
Toronto, Ontario M9W 5B1
Canada
888-761-7732
www.specfurniture.com

482f. Upholstered seating
Carrara
Kwalu
Atlanta, GA 30328
877-695-9258
www.kwalu.com

#482f

482g. Upholstered seating
Arcadia Series
Blockhouse Company, Inc.
York, PA 17406
800-346-1126
www.blockhouse.com

482h. Upholstered seating
Sierra Series chairs with open arms
Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#482h

482i. Upholstered seating
Skye Plus ASKYP1-400
Pineapple Contracts, Inc.
Clawson, MI 48017
800-496-9324
www.pineapplecontracts.com

482j. Upholstered seating
Domus Lounge Seating
Pineapple Contracts, Inc.
Clawson, MI 48017
800-496-9324
www.pineapplecontracts.com

482k. Upholstered seating
Chaise Lounge Chair
Blockhouse Company, Inc.
York, PA 17406
800-346-1126
www.blockhouse.com

483a. Rockers
RockSmart
Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

483b. Rockers
Hardi Rocking Chair
Spec Furniture
888-761-7732
specfurniture.com

483c. Rockers

Endurance Series Rocker

Blockhouse Company, Inc.
York, PA 17406
800-346-1126
www.blockhouse.com

#483c

484a. PVC molded seating

Forté™ Lounge

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#484a

484d. PVC molded seating

Hondo® Nuevo

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#484d

12 56 70 – Healthcare Furniture

485a. Tables

Jupiter Series Tables

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#485a

485b. Tables

Madera Series Tables

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#485b

485c. Tables

Tabla Series Drum Tables

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#485c

490a. Electrically adjustable hospital bed

Behavioral Health Bed™

Sizewise
Lenexa, KS 66215
800-814-9389
www.sizewise.com

#490a

490b. Electrically adjustable hospital bed

Spirit Bed with Mental Health Package

CHG Hospital Beds
London, ON N6E 1R6
Canada
866-516-5446
www.chgbeds.com

#490b

490c. Electrically adjustable hospital bed

MedSurg Bed #S3

Stryker
Kalamazoo, MI 49002
269-385-2600
www.stryker.com

#490c

490d. Electrically adjustable hospital bed

Mental Health Electric Bed

Umano Medical, Inc.
G0R 2Co, Canada
1-844-409-4030
www.umanomedical.com

#490d

491a. Bedding

One Piece Comfort and Safety Linen

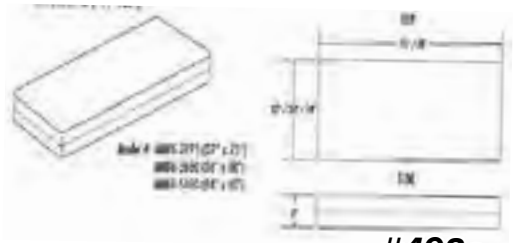
Harm Reduction Solutions
San Diego, CA 92117
858-500-2110
www.harmreductionsolutions.com

#491a

492a. Behavioral health mattresses

Comfort Shield® Remedy Sealed Seam Mattress

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com



#492a

492b. Behavioral Health Mattresses

Victory Series Mattresses

Sizewise
Lenexa, KS 66215800-814-9389
www.sizewise.net

492c. Behavioral health mattresses

Behavioral Health Mattress with Bed Bug Prote...
BioArmour™ Infection Control Composite Lamina...
Surface

American Innovation Products
Trinity, NC 27370
814-490-0660
www.americaninnovationproducts.com

#492c

492d. Behavioral health mattresses

Closed System™ Behavioral Health Mattress

Comfortex®
Winona, MN 55987
800-445-4007
www.comfortexinc.com

493a. Platform bed

Attenda Series Roto Cast Bed

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#493a

493d. Platform bed

Behavioral Health Beds # BHBP/68 and BHHD/68

Nemschoff
Sheboygan, WI 53081
800-203-8916
www.nemschoff.com

#493d

493e. Platform bed

Pineapple; Sovie Bed 1SVFA-100

Pineapple Contracts, Inc.
Clawson, MI 48017
800-496-9324
www.pineapplecontracts.com

493g. Platform bed

Behavioral Health Bed™ - Platform

Sizewise
Lenexa, KS 66215
800-814-9389
www.sizewise.com

#493g

493h. Platform bed

Frontier bed

Stance Healthcare
Kitchener, ON N2C 0B8
877-395-2623
www.stancehealthcare.com

#493h

494a. Platform bed – lift-accessible

Sleigh Bed

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#494a

494b. Platform bed riser – lift-accessible

Platform Bed Riser

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#494b

495a. Patient room furniture

VISTA Series

Blockhouse Company, Inc.
York, PA 17406
800-346-1126
www.blockhouse.com

#495a

495b. Patient room furniture

Safehouse Series

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#495b

495c. Patient room furniture
Safe & Tough series
This End Up® Furniture Company, Inc.
Sanford, NC 27331
800-605-2130
www.thisendup.com/groupliving.com


#495c

495d. Patient room furniture
Endurance Series
Cortech® USA
Willowbrook, IL 60527
800-571-0770
www.cortechusa.com


#495d

495e. Patient room furniture
Attenda Series
Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com


#495e

496a. Patient room cabinets
Fortress Wardrobes
Moduform
Fitchburg, MA 01420
800-221-6638
www.moduform.com


496b

496b. Patient Room cabinets
Frontier bedside cabinet – flip style
Stance Healthcare
Kitchener, ON N2C 0B8
877-395-2623
www.stancehealthcare.com


#496e

496c. Patient Room cabinets

CPAP Cabinet

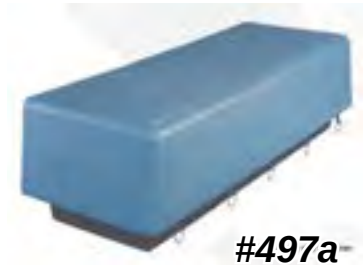
Blockhouse Company, Inc.
York, PA 17406
800-346-1126
www.blockhouse.com

496c

497a. Restraint bed

450 Series Seclusion Beds (restraint loops optional)

Moduform
Fitchburg, MA 01420
800-221-6638
www.moduform.com



#497a

497b. Restraint bed

Duraguard bed with side bars

Glasspec Corporation
Miami, FL 33256-0116
800-328-0888
www.glasspec.com

#497b

498a. Removable Restraint Loops

Attenda Restraint Rings (for use with Attenda beds)

Norix Group, Inc.
West Chicago, IL 60185
800-234-4900
www.norix.com

#498a

498b. Removable Restraint Loops

Restraint Adapter and Buckle System

SydLo Design LLC
South Range, Wisconsin
218-310-4351
SydLoDesignLLC.com

#498b

499a. Nurse servers
WALLAroo®
Carstens®, Inc.
Chicago, IL 60706
800-782-1524
www.carstens.com


#499a

499b. Nurse servers
Proximity EXT-28
Proximity Systems
800-437-8111
www.proximiitysystems.com

#499b

12 93 43 – Site Furnishings - Seating and Tables

510. Outdoor Furniture
Hilltop Outdoor Furniture
Norix Group, Inc.
West Chicago, IL 60185
1-800-234-4900
www.norix.com


#510

21 00 00 - Fire Suppression

21 13 13 - Fire Suppression Sprinkler Systems

520a. Fire sprinklers
Raven 5.6K Institutional Sprinklers
TYCO Fire Protection Products
Lansdale, PA 19446
800-523-6512
www.tyco-fire.com


#520a

520b. Fire sprinklers
819-S17 SR Sprinkler
Weizel Security
800-308-3627
www.securinghospitals.com

521a. Fire extinguisher cabinet

BestCare® Ligature-Resistant Recessed Fire Extinguisher Cabinet WH1704

Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

#521a

22 43 00 – Plumbing Fixtures

22 43 13 – Healthcare Water Closets

531. Toilet fixture, ADA–floor-mounted, back outlet

Huron EverClean Flushometer Toilet with integral seat

American Standard
Piscataway, NJ 08855
800-488-8049
www.americanstandard-us.com

#531

533. Solid-surface toilet fixture

CWC-156 AST-FF Behavioral HealthCare Toilet

Intersan Manufacturing Company
Phoenix, AZ 85007
602-254-3101
www.intersan.us

#533

534a. Stainless steel toilet

ETW-1490 Series

Willoughby Industries
Indianapolis, IN 46268
800-428-4065
www.willoughby-ind.com

#534a

534b. Toilet fixture – stainless steel

BestCare® Ligature-Resistant Toilet, Wall Supply, WH2142-W

Whitehall Manufacturing
City of Industry, CA 91744
800-782-7706
www.whitehallmfg.com

#534b

536. Bariatric toilet fixtures

BET-1490 Series – Bariatric toilets

Willoughby Industries
Indianapolis, IN 46268
800-428-4065
www.willoughby-ind.com

#536

22 43 16 – Healthcare Sinks

540a. Wall-Hung Corner Lavatories

BestCare® Ligature-Resistant, ADA Compliant Corterra Cast Solid Surface Corner Basin; WH3776 Series

Whiteall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

#540a

541a. Wall-Hung Lavatories

HSL1 SafeCare Ligature-Resistant Lavatory – stainless steel or high- impact polymer trap cover

Bradley Corporation
Menomonee Falls, WI 53051
800-272-3539
www.bradleycorp.com

#541a

542a. Vanity top lavatory

Suicide Prevention Patient Sink Faucet

Norva Plastics, Inc
Norfolk, VA 23508
800-826-0758
www.norvaplastics.com

#542a

542b. Vanity top lavatory

Avonite® Acrylic Solid Surfaces

Avonite Surfaces
Florence, KY 41042
800-354-9858
www.avonite.com

#545

545. Hand Washing

Wallgate; Thrii (soap, water, drying)

Intersan Manufacturing Company
Phoenix, AZ 85007
602-254-3101
www.intersan.us

#545

22 43 19 – Healthcare Bathtubs and Showers

550a. Shower head – ligature resistant

SP-7 Shower Head

Odd Ball Industries Mfg. Co., Inc.
Greenlawn, NY 11740
631-754-0400
www.oddballindustries.com

#550a

550c. Shower head – ligature resistant

Ligature-Resistant Shower Head – SH330

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

552a. Shower Control Valve

#550c

WH538-CSH Ligature-Resistant Shower Head and Valve

Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com


#563c

552b. Shower valve

Ligature-Resistant Shower Valve – SV230

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com


#552b

552c. Shower valve

834-S40 SRTM Retrofit Shower Knob

Weizel Security
800-308-3627
www.securinghospitals.com


#552c

552d. Shower valve

Sense™ DMV2 – Individual Shower concealed electronic mixing valve with optional stainless steel cover

Armstrong International
Three Rivers, MI 49093
269-273-1415
www.armstronginternational.com


#552d

555a. Shower diverter valve

834-SN2 SRTM Diverter Valve Assembly

Weizel Security
800-308-3627
www.securinghospitals.com


#555a

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560a. Shower assembly

BestCare® Flush-Mount Ligature-Resistant Security Shower WH1741-CSH

Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

#560a

560b. Shower assembly

SR834-S35 SRTM Shower Panel

Weizel Security
800-308-3627
www.securinghospitals.com

#560b

560c. Shower assembly

Ligature-Resistant Shower Panel #SV710

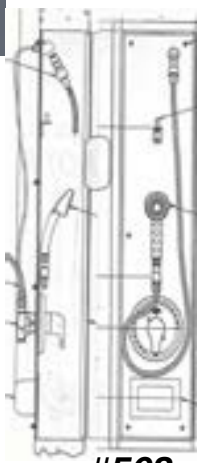
Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#560c

562. Shower assembly – recessed hand-held

M0418-E508 in locking box

Acorn Engineering
City of Industry, CA 91746
800-488-8999
www.acorneng.com



#562

563a. Shower assembly – handicapped accessible

Dual Quick Connect – Wall Mounted Shower Head with Integral Diverter #42020US

Intersan Manufacturing Company
Phoenix, AZ 85007
602-254-3101
www.intersan.us

#563a

563b.Shower assembly – handicapped accessible

Quick release hand held shower head; Model 40707

Intersan Manufacturing Company
Phoenix, AZ 85007
800-999-3101
www.intersanus.com

#563c

563c. Shower assembly – handicapped accessible

BestCare® Flush-Mount Ligature-Resistant Security Shower with Dual Heads WH1741-FH-CSH

Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

#563c

22 43 23 – Shower Receptors and Basins

564a. Shower linear drain

ProLine drain with "dots" cover

QuickDrain USA
Frisco, CO 80443
866-998-6685
www.quickdrainusa.com

#564a

565a. Ligature Resistant Drain Cover

Crocodile Roll Resistant Floor Drain; 303070X

Intersan Manufacturing Company
Phoenix, AZ 85007
800-999-3101
www.intersanus.com

#565a

565b. Ligature Resistant Drain Cover

Tower Industries; Anti-Ligature Drain Cover – Model SDC-AL-1-S

Tower Industries
Massillon, OH 44647
330-837-2216
www.towershowers.com

#565b

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565c. Ligature Resistant Drain Cover

BestCare® Ligature-Resistant Floor Drain Grate WHDG Series

Whitehall Manufacturing
City of Industry, CA 91746
800-782-7706
www.whitehallmfg.com


#565c

565d. Ligature Resistant Drain Cover

BestCare® Ligature-Resistant Linear Drain with Flashing Flange WHLD Series

Whitehall Manufacturing
City of Industry, CA 91746
800-782-7706
www.whitehallmfg.com


#565d

566. One-piece patient toilet room floor

UniFloor

Bestbath®
Caldwell, ID 83605
800-727-9907
www.bestbath.com


#566

567a. Shower floor basin

The Swan Corporation, Swanstone Solid Surface Shower Floors

The Swan Corporation
St. Louis, MO. 63101
1-314-231-8148
www.theswancorp.com


#567

567b. Shower floor basin

Roll-in shower with front trench

Watermark
Nashville, TN 37204
615-291-6111
www.watermarksolidsurface.com


#567b

567c. Shower floor basin

AquaSurf solid surface shower bases

Willoughby Industries
Indianapolis, IN 46268
800-428-4065
www.willoughby-ind.com

#567c

568a. Pre-built bathrooms

Pre-Built Bathrooms

Eggrock, LLC
Littleton, MA 01460
978-952-8800
www.eggrock.com

#568a

568b. Pre-built bathrooms

SurePods™

Oldcastle®
Orlando, FL 32837
407-859-7034
https://oldcastlesurepods.com

22 43 39 – Healthcare Faucets

570a. Lavatory faucet

Ligature-Resistant Metering Faucet – SF380

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#570a

570b. Lavatory faucet

Suicide Prevention Patient Sink Faucet

Norva Plastics, Inc
Norfolk, VA 23508
800-826-0758
www.norvaplastics.com

#570b

570c. Lavatory faucet

BestCare® Ligature-resistant, ADA-compliant faucet 3377 w/2 two pneumatic buttons

Whiteall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

3570c

570d. Lavatory faucet

BestCare® Ligature-resistant, ADA-compliant Sensor faucet #WH3375-SO

Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

#570d

574. Lavatory with countertop valve

Lavatory Valve

Odd Ball Industries
Greenlawn, NY 11740
631-754-0400
www.oddballindustries.com

#574

22 43 43 – Plumbing Fixture Flushometers

580. Recessed flush valve

Royal 611 & WB-1-A Easy Access Wall Box

Sloan®
Franklin Park, IL 60131
800-982-5839
www.sloan.com

#580

581a. Recessed flush valve

Regal 955 Hydraulic Concealed Flushometer & WB-1-A Easy Access Wall Box

Sloan®
Franklin Park, IL 60131
800-982-5839
www.sloan.com

#581a

581b. Recessed flush valve

CX Manual Flushometer (Recessed)

Sloan®
Franklin Park, IL 60131
800-982-5839
www.sloan.com

#581b

581c. Recessed flush valve

3-inch Push Button Assembly for Concealed Flush Valves – P6000-NL3

Zurn Industries
Milwaukee, WI 53204
855-663-9876
www.zurn.com

#585a

585a. Flush valve cover

HSC79 SafeCare Ligature-Resistant Flush Valve Cover

Bradley Corporation
W142N9101 Fountain Boulevard Menomonee Falls, WI 53051
800-272-3539
www.bradleycorp.com

585b. Flush valve cover

FV500 (2 piece) & FV600 (1 piece) Ligature Resistant Flush Valve Cover

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#585b

585c. Flush valve cover

831-S39 SRTM Flush Valve Cover

Weizel Security
Coquitlam, BC, Canada V3K 6V5
800-308-3627
www.securinghospitals.com

#585c

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

585d. Flush valve cover

Ligature-Resistant Box with Flush Valve WH2802 – for various toilet or urinal

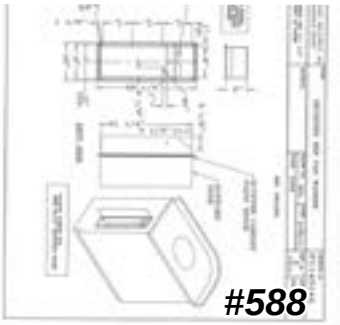
Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com


#585d

588. Recessed bedpan washer

Recessed Bedpan Washer

Willoughby Industries
Indianapolis, IN 46268
800-428-4065
www.willoughby-ind.com


#588

22 47 00 – Water Station Water Coolers

589a. Drinking water cup filling stations

B103-C2-HR Water Bottle Filling Station Cup Dispenser and Disposal with security features

Filtrine Manufacturing Company
Keene, NH 03431
800-930-3367
www.filtrine.com


#589a

589b. Drinking water cup filling stations

Quench 755 Countertop Filtered Water Cooler with UV

Quench
King of Prussia, PA 19406
888-877-0561
www.quenchonline.com


#589b

589c. Drinking water cup filling stations

Pushbutton Ligature-Resistant Cup Filler – WHBF3

Whitehall Manufacturing
City of Industry, CA 91744-0527
800-782-7706
www.whitehallmfg.com

#589c

22 60 00 – Gas and Vacuum Systems

590a. Medical gas covers

Security Patient Console

Hospital Systems, Inc.
Pittsburg, CA 94565
925-427-7800
www.hsiheadwalls.com

#590a

590b. Medical gas covers

Recessed Security Console

Modular Services Company
Oklahoma City, OK 73114
800-687-0938
www.modularservices.com/products-services/

#590b

590c. Medical gas covers

Security Headwalls w/ 3/8" polycarbonate locked cover bottom hinge

Modular Services Company
Oklahoma City, OK 73114
800-687-0938
www.modularservices.com
www.filtrine.com

#590c

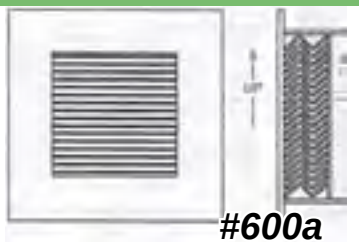
23 00 00 – Heating, Ventilating, A/C

23 37 13 – Diffusers, Registers and Grilles

600a. Air grille - “S” vane

Security Grille – “S” vane # RSPA41

Carnes® Company
Verona, WI 53593
608-845-6411
www.carnes.com

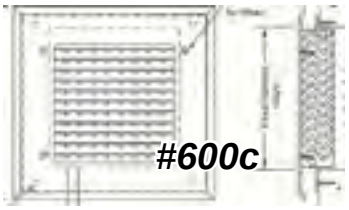


#600a

600c. Air grille - “S” vane

V-Vent High Security Grille #814-R17 SRTM

Weizel Security
800-308-3627
www.securinghospitals.com

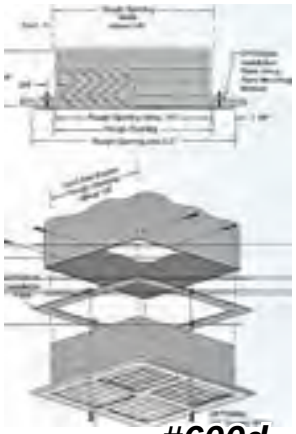


#600c

600d. Air grille - “S” vane

Maximum Security Ceiling Diffuser # SV432

Anemostat® Air Distribution
Carson, CA. 90745
310-835-7500
www.anemostat.com



#600d

602a. Air grille – max security

Extra Heavy Duty Grille with Removable Steel Perforated Face Plate # RRMX

Anemostat® Air Distribution
Carson, CA. 90745
310-835-7500
www.anemostat.com

#602a

602b. Air grille – max security

Maximum Security Suicide Deterrent Grille, steel with 3/16-inch holes # SG-SD

Titus
Plano, TX 75074
972-212-4800
www.titus-hvac.com

#602b

603a. Air grilles - Perforated

Security Grille – Perforated # RSPA51

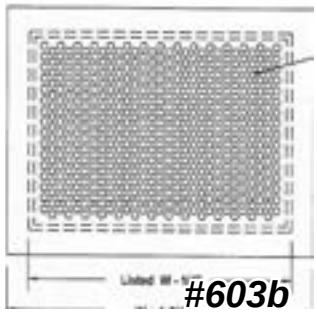
Carnes® Company
Verona, WI 53593
608-845-6411
www.carnes.com

#603a

603b. Air grilles - Perforated

Security Grille – supply or return # SEG-4P3

Kees Incorporated
Elkhart Lake, WI 53020-0327
920-876-3391
www.kees.com



#603b

603c. Air grilles - Perforated

Ligature-Resistant Exhaust/Supply Grille #EG450

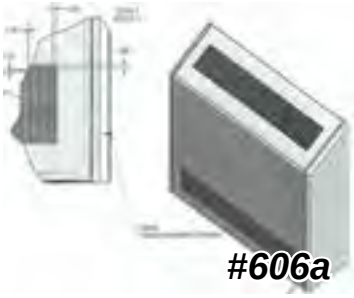
Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

#603c

606a. Fan coil enclosures

Fan Coil Covers - Security

ARSCO Manufacturing Company
Cincinnati, OH 45248
800-543-7040
www.arscomfg.com



#606a

609b. Air grilles - Perforated

Ligature-Resistant PTAC Cover #TA640

Behavioral Safety Products
Watkinsville, GA 30677
706-705-1500
www.besafepro.com

609b

607a. Room Temperature Sensor – tamper-resistant

Flush-Mount Thermistor; KTP Series Stainless Steel

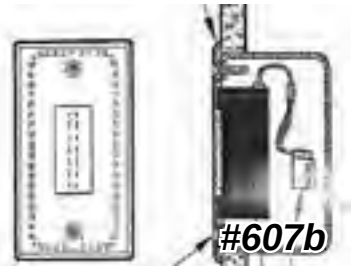
Kele, Inc.
Bartlett, TN 38133
877-826-9045
www.kele.com

#607a

607b. Room Temperature Sensor – tamper-resistant

Flush-Mount Room Temperature Sensor #540-520

Siemens Building Technologies, Inc.
1000 Deerfield Parkway
Buffalo Grove, IL 60089
www.siemens.com



#607b

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26 27 26 – Electrical Devices

610a. Hospital-grade receptacles

Hospital Grade Tamper-Resistant GFCI Receptacles

Hubbell Incorporated
Shelton, CT 06484
800-288-6000
www.hubbell-wiring.com

#610a

610b. Hospital-grade receptacles

Hospital Grade Tamper-Resistant GFCI Receptacles

Cooper Industries
Houston, TX 77210-4446
713-209-8400
www.cooperindustries.com

#611a

611a. Key-operated electric switches

Pass & Seymour Locking Keyed Switch

Legrand North America, LLC
http://www.legrand.us/passandseymour.aspx

611b. Key-operated electric switches

Leviton 1221-2KL Key Locking Extra Heavy Duty Switch

Leviton Manufacturing Co., Inc.
www.leviton.com

#611b

612a. Polycarbonate electrical coverplates

Tiger Plates

Cortech® USA
Willowbrook, IL 60527
800-571-0700
www.cortechusa.com

#612a

26 51 00 – Interior Lighting

620a. Light fixture

NASL-RND LED 2' diameter w/ flat polycarbonate lens

Day-O-Lite
Warwick, RI 02888
401-467-8232
www.dayolite.com

#620a

620b. Individual reading light

Symmetry tamper-resistant light fixture

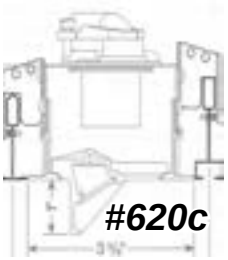
Visa Lighting
Milwaukee, WI 53209
www.visalighting.com

#620b

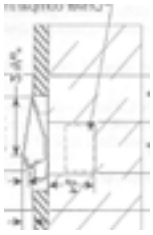
620c. Light fixture

Fino® ceiling mount and wall mount light fixtures

Amerlux®, LLC
Oakland, NJ 07436
973-882-5010
www.amerlux.com



#620c



#620c

620d. Light fixture

Mighty Mac TW Series TUNABLE Color SSA Slope Sided Surface Mount or RMCD Recessed Mount vandal resistant light fixtures

Kenall®
Kenosha, WI 53144
800-453-6255
www.kenall.com

#620d

620e. Light fixture

Fail-Safe SGI recessed, sealed, and gasketed with polycarbonate lens

Eaton's Cooper Lighting
Peachtree City, GA 30269
770-486-4800
www.cooperindustries.com

#620e

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

620f. Light fixture

818-R13 SRTM Recessed Ceiling Lighting with polycarbonate lens

Weizel Security
800-308-3627
www.securinghospitals.com


#620f

620g. Light fixture

~~Serenity -~~ Vissage Series

Visa Lightin
Milwaukee, WI 53209
800-788-8472
www.visalighting.com


#620g

620h. Light fixture

Ligature & Vandal-Resistant 6" LED downlight #MRV-06858

Kirlin Company
Detroit, MI 48207
313-259-6400
www.kirlinlighting.com


#620h

620j. Light fixture

Sonar 12 SPC12 Vandal Resistant wall mount fixture

Luminaire Lighting Corporation
P. O. Box 2162
Edison, NJ 08818
732-549-0056
www.luminairelighting.com


#620j

620k. Light fixture

Shat-R-Shield - Ironclad VR Pro surface mounted vandal-resistant fixture #494F12

Grainger
Lake Forest, IL 60045
800-472-4643
www.grainger.com


#620k

620l. Light fixture

Vandal Resistant round wall/ceiling mount fixture Anyx-13, ARV-13

Luminaire Lighting Corporation
Edison, NJ 08818
732-549-0056
www.luminairelighting.com


#620l

620m. Light fixture

Kenall MedMaster MedSlot Series

Kenall®
Kenosha, WI 53144
800-453-6255
www.kenall.com

#620m

620n. Light fixture

Fail-Safe FW WaveStream Wall LED Luminaire

Eaton Lighting
770-486-4800
www.eaton.com/lighting

#620n

624. Individual reading light

Visa Lighting; Gig with BH1 mounting bracket & polycarbonate lens

Visa Lighting
Milwaukee, WI 53209
800-788-8472
www.visalighting.com

#624

630. Downlight cover

Recesso Lights

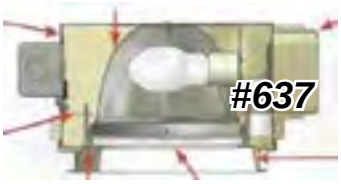
Recesso Lighting by Dolan Designs
Kirkland, WA 98034
877-357-6127
http://recessolighting.com

#630

637. Exterior lighting

Exterior Vandal Resistant Lighting

The Kirlin Company
Detroit, MI 48207
313-259-6400
www.kirlinlighting.com



#637

Inclusion or exclusion of a product does not indicate endorsement or disapproval of that product, nor does it suggest that any product is free of risk. All products must be in compliance with the Safety Risk Assessment for each location.

639a. Night-light

LNT-03092 Night Light

The Kirlin Company
Detroit, MI 48207
313-259-6400
www.kirlinlighting.com

639b. Night-light

CM-25500 PathMaster Step Light

Phillips Lighting North America Corp.
(Chloride)
Somerset, NJ 08873
855-486-2216
www.lightingproducts.phillips.com

#639b

26 53 00 – Exit Signs

640a. Exit signs, LED – vandal-resistant

Commercial Exist Signs SC Series – Cast Aluminum LED wit[illegible] lens and tamperproof hardware

Philips Lighting North America Corporation (Chloride)
Somerset, NJ 08873
855-486-2216
www.lightingproducts.philips.com

#640a

640b. Exit signs, lighted – vandal-resistant

Mighty Mac MMEX Surface, Wall, or Ceiling Mount Single/Double Face Exit w/ full-length mounting canopy

Kenall®
Kenosha, WI 53144
800-453-6255
www.kenall.com

#640b

642. Exit signs - photoluminescent

EX424246-100G Ecoglo® Photoluminescent Exit Sign

Access Products Inc.
Buffalo, NY 14203
888-679-4022
www.us.ecoglo.com

26 55 53 – Security Lighting

643. Covers

Norva Plastics – Life/Fire Safety Lexan Covers

Norva Plastics, Inc
Norfolk, VA 23508
800-826-0758
www.norvaplastics.com

27 00 00 – Communications

27 32 13 – Telephone Sets

645a. Stainless steel wall phones

GB306V-14 Vandal-Resistant Telephone with 14" armored cord

Allen Tel Products, Inc.
Henderson, NV 89014
702-855-5700
www.allentel.com

645b. Stainless steel wall phones

SSW-321-X Ceeco Stainless Steel Wall Phone

TWAcomm.com
Fountain Valley, CA 92708
877-389-0000
www.twacomm.com

645c. Stainless steel wall phones

JP3500 Armored Courtesy Phone

G-Tel Enterprises, Inc.
Houston, TX 77084
800-884-4835
www.payphone.com

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27 52 23 – Nurse Call/Code Blue Systems

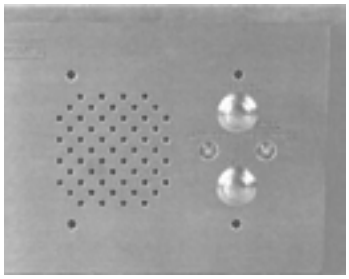
650a. Wireless duress alarm
INSTANTalarm® 5000
Pinpoint®, Inc.
Birmingham, AL 35209
205-414-7541
www.pinpointinc.com


#650a

650f. Wireless duress alarm
B3000n Communication Badge
Vocera®
San Jose, CA 95126
888-986-2372
www.vocera.com


#650f

653. Nurse call system – vandal-resistant
HSS401 Responder Health Care Communications System High Security Staff Duty Station
Rauland-Borg Corporation
Mount Prospect, IL 60056
800-752-7725
www.rauland.com


#653

654. Pushbutton switch – vandal-resistant
PV1-PV8 Anti-Vandal Switches
Lamb Industries
Minneapolis, MN 55428
800-867-2717
http://www.e-switch.com/


#654

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28 00 00 – Electronic Safety and Security

28 40 00 – Electronic Monitoring and Control

660. Metal Detectors

Metrasens; Proscreen 200

Metrasens
Lisle, IL 60532
630-541-6509
http://www.metrasens.com/

32 00 00 – Exterior Improvements

32 31 13 – Security Fencing

675a. Security fencing

Mini-Mesh chain-link fencing

Fence Factory
Agoura Hills, CA 91301
800-613-3623
www.fencefactory.com

675b. Security fencing

WireWall® High Security Fencing - Maximum Security

Riverdale Mills Corporation
Northbridge, MA 01534
800-762-6374
www.riverdale.com

675c. Security fencing

Steel fence systems

METALCO Fence & Railing Systems, Inc.
Las Vegas, NV 89102
800-708-2526
fence-system.com

675d. Security fencing

Fortress Fencing

Britplas
Woolston
Warrington, Cheshire, England WA1 4RW
+44(01)-1925-824317
www.britplas.com

About the Authors

Kimberly Newton McMurray, AIA, EDAC, NCARB, MBA is Principal of Behavioral Health Facility Consulting, LLC. of Tuscaloosa, Alabama; an organization that consults with behavioral health organizations and architects who design behavioral health facilities regarding their unique requirements for patient and staff safety. McMurray is a licensed architect and healthcare planner with over 35 years of project leadership experience in healthcare and academic medical campus architecture; she has been responsible for the implementation of large architectural projects located within complex medical campus sites, delivering the highest quality for each project initiative. McMurray has a decade of experience from the owner's perspective and working with multi-disciplinary user groups, thereby embracing a unique perspective and response to client needs; applying her knowledge of clinical operations, evidence-based design, lean operational planning and conceptual design to architecture. Among McMurray's three decades of healthcare architectural expertise, she brings a high-level of experience with behavioral and mental health project types. She has assisted in over 65 behavioral and mental health facility space programs, master plans, designs and PSSRs since joining BHFC in 2017. She can be reached at kimberly@bhfcllc.com.

James M. Hunt, AIA, is a retired architect and facility management professional with more than 40 years of experience. He is a registered architect and began his career practicing architecture for several major health care projects. He then served as director of facility management for the Menninger Clinic for 20 years. In addition to managing the clinic's main campus, he consulted on behavioral health care unit remodeling projects for their Clinical Network program in eight states. During this time, Mr. Hunt was a founding member of the Health Care Council of the International Facility Management Association. He held several offices in the council, including chair. He publishes articles and speaks at major conferences frequently. He is founder and Retired Senior Consultant of Behavioral Health Facility Consulting, LLC (BHFC), an organization that consults with behavioral health organizations and architects who design behavioral health facilities regarding their unique requirements for patient and staff safety. He has worked with behavioral health facilities in more than 40 years and may be reached at www.bhfcllc.com.

David M. Sine, DrBE, CSP, ARM, CPHRM - 25 years in safety, risk management, human factors, and organizational consulting. He has been state safety director of two eastern states, senior staff engineer for the Joint Commission, and a senior consultant for the American Hospital Association. Founding partner and one-time contributing editor for Briefings on Hospital Safety, co-author of Quality Improvement Techniques for Hospital Safety, and one-time vice chair of the board of Brackenridge Hospital in Austin, Texas, Mr. Sine is certified by the Joint Board of the American Board of Industrial Hygiene and Certified Safety Professionals and as a Certified Professional Healthcare Risk Manager by ASHRM. He has been a health care risk management consultant since 1980 and has conducted more than 1,300 Joint Commission compliance assessment surveys. He serves as a member of the NFPA 101 Life Safety Code Subcommittee on Health Care Occupancies, the Joint Commission Committee on Healthcare Safety, and the FGI Health FGI Guidelines Revision Committee and acts as a risk management adviser to the National Association of Psychiatric Health Systems. He served in the corporate offices of the Tenet Health System in Dallas as director of risk assessment and loss prevention and vice president of occupational health and safety. Mr. Sine continues to write and lecture extensively on health care policy, governance, quality improvement, and risk management as President of SafetyLogic Systems. He can be reached at dsine9@gmail.com.

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List of Manufacturers

Access Products,
www.us.ecoglo.com

Accurate,
www.accuratelockandhardware.com

Ace Security,
www.smashandgrab.com

Acorn Engineering Co.,
www.acorneng.com

Allen Tel Products,
www.allentel.com

Alro Plastics,
www.alro.com

American Innovation,
www.americaninnovationproducts.com

American Specialties,
www.americanspecialties.com

American Standard,
www.americanstandard-us.com/

Anemostat,
www.anemostat-hvac.com

Archer Manufacturing,
www.vandalproof.org

Armstrong Ceiling Solutions,
www.armstrongceilings.com

Armstrong Flooring,
www.armstrong.com

Armstrong International,
http://armstronginternational.com

Arsco,
www.arscomfg.com

Avonite,
www.avonitesurfaces.com

BASF,
www.master-builders-solutions.basf.us

Behavioral Safety Products,
www.besafepro.com

Best Access Solutions, Inc.,
http://www.bestaccess.com/index.php/products/behavioral-health-products/

Bath,
www.best-bath.com

Big John,
www.bigjohntoiletseat.com

Blockhouse,
www.blockhouse.com

Bradley,
www.bradleycorp.com

Brey-Krause
www.breykrause.com

Britplas,
www.britplas.com

Carnes,
www.carnes.com

Carstens,
www.carstens.com

Cascade,
www.cascadesh.com

Ceco,
www.cecodoor.com

CHG,
www.chgbeds.com

Chloride,
www.chloridesys.com/chloride

CompX,
www.compx.com

Comfortex,
www.comfortex.com

Cooper,
www.cooperindustries.com

Cortech,
www.cortechusa.com

CS Acrovyn,
www.c-sgroup.com

Curries,
www.curries.com

Custom Design Frameworks,
www.customdesignframeworks.com

Dano Group,
http://www.danogroup.com

Designplan,
www.designplan.com

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Dex-O-Tex,
www.dexotex.com

DHSI,
www.dhsi-seal.com

Door Control Services,
www.doorcontrolsusa.com

Door Switch,
http://thedoorswitch.com

Draper, Inc.,
www.draperinc.com

Dur-A-Flex,
www.dur-a-flex.com

Dynalock Corp,
www.dynalock.com

Eggrock,
www.eggrock.com

Fence Factory,
www.fencefactory.com

Filtrine Manufacturing Co.;
www.filtrine.com

Flexco,
www.flexcofloors.com/

Flxsigns,
www.290signs.com

G-Tel,
www.payphone.com/

Glasspec Corporation,
www.glasspec.com

Global,
www.security-glazing.com

GoJo Industries,
www.GOJO.com

Grahan Wood Doors,
www.grahamdoors.com

Grainger,
www.grainger.com

Hafele,
www.hafele.com/us/index.htm

Hager Companies,
www.hagerco.com

Harm Reduction Solutions,
www.harmreductionssolutions.com

Hospital Systems Inc.,
www.HospitalSystems.com

Hubbell,
www.hubbell-wiring.com

IE; Blinds,
www.ieblinds.com

Intersan,
www.intersan.us

Ives,
http://us.allegion.com/

J. L. Industries,
www.jlindustries.com

Johnsonite,
www.roppe.com

Kane Mfg.,
www.kanescreens.com

Kawneer Company, Inc.,
www.kawneer.com

Kees,
www.kees.com

Kele, Inc.,
www.kele.com

Kenall,
www.kenall.com

Kennon Products,
www.suicideproofing.com

King Architectural Products,
www.kingarchitecturalproducts.com

Kingsway Group USA
www.kingswaygroupusa.com

Kirlin,
www.kirlinlighting.com

Kwalu,
www.kwalu.com

L. C. Doane,
www.lcdoane.com

LCN,
http://us.allegion.com/brands/lcn/Pages/default.aspx

Lamb Industries,
www.e-switch.com

Lee's Carpet,
www.leescarpets.com

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Lonseal,
http://lonseal.com

Luminaire,
www.luminairelighting.com

Manko Windows,
www.mankowindows.com

Maiman,
www.maiman.com

Marathon,
www.flexcofloors.com

Markar,
https://www.assaabloydooraccessories.us/en/local/assaabloydooraccessoriesus/products/hinges/continuous-pin-barrel-hinges/behavioral-health-hinges/

Marks USA,
www.marksusa.com

Marshfield Door Systems, www.marshfielddoors.com

McMaster-Carr,
www.mcmaster.com

Metalco,
www.fence-system.com

Metrasens,
www.metrasens.com

Mockett, Doug,
www.mockett.com

Moduform,
www.moduform.com

Modular Services Company,
www.modularservices.com

National Gypsum,
www.nationalgypsum.com

Nemschoff,
www.nemschoff.com

Nora Systems, Inc.;
www.nora.com/us

Norix,
www.norix.com

Northwest Specialty Hardware.
www.northwestsh.com

Norva Plastics,
www.norvaplastics.com

Odd Ball,
www.oddballindustries.com

O'Keeffe's, Inc.,
www.safti.com

Oldcastle,
www.oldcastlebe.com

Pabco Gypsum,
www.quietrock.com

Padded Surfaces,
paddedsurfaces.com/CAD.html

Pecora,
www.pecora.com

Peerless A-V,
www.perlessmounts.com

Pineapple,
www.pineapplecontracts.com

Pinpoint,
www.pinpointinc.com

Quench;
www.quenchonline.com

Quick Drain USA,
www.quickdrain.com

RAL & Associates,
www.ieblinds.com

Rauland - Borg Corp.,
www.rauland.com

Re*cesso Lights,
http://recessolighting.com/

Riverdale Mills,
www.wirewall.com

ROA Contract Sales,
www.rao.com

Rockwood,
www.rockwoodmfg.com

Roppe,
www.roppe.com

Sabic,
www.sabic.com

SaftiFirst (O'Keeffe's, Inc.),
www.safti.com

Safehinge-Primera
www.safehingeprimera.com

Sani-liner,
www.wisconsinconverting.com

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Sargent Lock,
www.sargentlock.com

Schlage,
http://us.allegion.com

Scotchshield,
http://solutions.3m.com/

Securitech Group, Inc.,
www.securitech.com

Sheffield,
www.sheffieldplastics.com

Sherwood Windows Group,
www.sherwoodwindows.com

Siemens Building Technology,
www.siemens.com

Sizewise,
www.sizewise.net

Sloan,
www.sloanvalve.com

Spec,
www.specfurniture.com

Stanley Hardware,
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www.stocorp.com

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www.stryker.com/en-us/products/

Sugatsune,
www.sugatsune.com

Surebond,
www.surebond.com

SydLo Design, LLC,
lrwendt02@gmail.com

Tamperproof Screws,
www.tamperproof.com

Technical Glass Products (TGP),
www.fireglass.com

This End Up,
www.thisendup.com

3M,
www.3m.com

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