STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, September 15, 2021

CF OPERATING PROCEDURE
NO. 155-61

Mental Health/Substance Abuse

RESIDENTIAL ROOM ASSIGNMENTS IN THE CIVIL FACILITIES

1. Purpose. This operating procedure describes a set of minimal standards to consider when determining bedroom assignments for individuals in civil treatment facilities.

2. Scope. This operating procedure applies to residents in civil mental health treatment facilities, whether operated by the Department of Children and Families or state contracted facilities.

3. References.

a. Chapter 394, Florida Statutes (F.S.), Mental Health.

b. Chapter 916, F.S., Mentally Deficient and Mentally Ill Defendants.

c. Rule 65E-20, Florida Administrative Code (F.A.C.), Forensic Client Services Act Regulation.

d. Rule 65E-5, F.A.C., Mental Health Act Regulation.

e. Rule 59A-3, F.A.C., Hospital Licensure.

f. Code of Federal Regulations, Title 42 – Public Health, Chapter IV – Centers for Medicare and Medicaid Services, Department of Health and Human Services, Subchapter G – Standards and Certification, Part 482 – Conditions of Participation for Hospitals, 482.13 Conditions of Participation: Patients' Rights, Final Rule, Amended May 16, 2012 [42CFR482.13].

g. Centers for Medicare and Medicaid Services, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Revision 105, 03-21-14.

h. Almvik, R., Risk Assessment Made Easy – The Broset Violence Checklist (BVC), *St. Olavs Hospital*, 2015.

i. Almvik, R., Woods, P. & Rasmussen, K. (2000). The Broset Violence Checklist: Sensitivity, Specificity, and Interrater Reliability. *Journal of Interpersonal Violence, 15*, 1284-1296

j. Ghosh, M., Twigg, D., Kutzer, Y., Towell-Barnard, A. & De Jong, G. (2019). The Validity and Utility of Violence Risk Assessment Tools to Predict Patient Violence in Acute Care Settings: An Integrative Literature Review. International Journal of Mental health Nursing, *28*, 1248 – 1267.

k. Gross, J. (2005). Aggression in an Inpatient Psychiatric Facility: A Retrospective Longitudinal Study. Dissertation.

l. Johnson, M. (2004). Violence on Inpatient Psychiatric Units: State of the Science. *Journal of the American Psychiatric Nurses Association, Vol. 10, No. 3:* 113-121.

This operating procedure supersedes CFOP 155-61 dated June 30, 2017.
OPR: SMF
DCF Tracker Assignment Number: A21-004144.

m. Ogloff, J. & Daffern, M. (2006). The Dynamic Appraisal of Situational Aggression: An Instrument to Assess Risk for Imminent Aggression in Psychiatric Inpatients. *Behavioral Sciences and the Law, 24*: 799-813.

4. Definitions. For the purposes of this operating procedure, the following terms shall mean:

a. Assessment. The systematic collection and integrated review of resident-specific data that includes efforts to identify key safety, medical, physical, intellectual, and psychological areas of clinical significance to guide treatment needs.

b. Bed Assignments. Resident room assignments within a unit or floor of the facility.

c. Gender Nonconforming. An adjective used as an umbrella term to describe people whose gender expression or gender identity differs from gender norms associated with their assigned birth sex. This may include physical appearance, clothing and accessory choices, and behaviors that express aspects of gender identity. Individuals may have or have not had gender reassignment surgery.

d. Personal Safety Plan (form CF-MH 3124, available in DCF Forms). A document which is completed by the resident, with assistance from facility staff, if needed. A personal safety plan is used as a guide to increase awareness of strategies which can assist each individual to avoid a crisis before one arises. The plan identifies calming strategies; actions that are "triggers" to a potential crisis situation; personal signs or signals of distress; individual preferences regarding staff interactions during a pre-crisis situation and the type of emergency intervention used; medications which the resident has found to be helpful in emergency situations; and, information regarding past traumatic experiences. This plan is reviewed by staff upon initial admission to the facility, after each seclusion or restraint event and is updated at least annually.

e. Resident. An individual receiving services in a state mental health treatment facility. The term is synonymous with "client," "consumer," "individual," "patient," or "person served."

f. Recovery Plan. A written plan developed by the resident and his or her recovery team. This plan is based on assessment data, identifying the resident's clinical, rehabilitative, and activity service needs, and the strategy for meeting those needs. This plan documents treatment goals and objectives, criteria for terminating the specified interventions, and documents progress in meeting specified goals and objectives.

g. Recovery Team. An assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate, community case manager, family member, and other treatment professionals as determined by the resident's needs.

5. Standards.

a. The health and safety of each resident shall be the primary concern of state mental health treatment facilities at all times. Therefore, when a resident demonstrates a potential threat to the safety of self or others, via a known history of verbal disagreements with another resident, current verbal threats, or demonstrates targeting behaviors toward others, the recovery team shall utilize each aggressor and potential victim's personal safety plan, review environmental concerns, and review clinical risk assessment factors for initial, transfer, and proactive or reactionary bed assignments.

b. Bed assignments shall not be used as punishment, for the convenience of staff, or as a substitute for treatment programs.

c. The Recovery Team is responsible for reviewing bed assignments and making determinations or adjustments based on safety, compatibility, and security needs of residents.

(1) The bed assignment determination requires a review of the Clinical Risk Assessment (CRA) within 120 hours of admission and will incorporate a review using additional risk assessment tools including the Dynamic Appraisal of Situational Aggression (DASA) and the Broset Violence Checklist (BVC). The DASA and BVC are included in Appendix A to this operating procedure.

(2) The DASA and BVC must be completed at the time of admission, upon transfer to another dorm/unit, following transfer from a forensic facility to a civil facility, and when any member of a recovery team identifies and documents a significant change of status in a resident which may affect bed assignment.

(3) Specific attention must be paid to prior known events of physical aggression resulting in injury as well as recent verbal altercations/threats between residents. Age differences and mobility also may need to be considered. After hours, weekends and on holidays the nursing supervisor or the shift supervisor or designee will review whether an observation area, dorm change, or use of comfort room is necessary to maintain safety on the dorm or floor.

d. The DASA and BVC must be completed and signed by one of the following professionals: licensed Psychologist, Registered Nurse, Advance Registered Nurse Practitioner, or Psychiatrist.

e. Upon admission to the facility and any time a bed assignment is change, determinations will be documented in the Recovery Team Meeting Minutes, including a discussion of factors considered and a rationale for the assignment. Consideration should be given to the following factors:

(1) Risk variables (or factors) for consideration include:

(a) Negative attitudes;

(b) Lack of insight;

(c) Active symptoms of major mental illness;

(d) Unresponsive to treatment;

(e) Impulsivity;

(f) Stress;

(g) Confusion;

(h) Irritability;

(i) Boisterousness;

(j) Verbal threats;

(l) Physical threats

(m) Attacks on objects;

(n) Unwillingness to follow directions;

(o) Sensitivity to perceived provocation; and,

(p) Easily angered when requests denied.

(2) Diagnostic or symptom factors for consideration include:

(a) Presence of a personality disorder (particularly Borderline or Antisocial);

(b) Paranoia;

(c) Suspiciousness and hostility coupled with manic or organic psychotic conditions; and,

(d) Moodiness, anger, resentment, agitation.

(3) Environmental factors for consideration include:

(a) Bed census greater than 80% capacity;

(b) Crowding and density on the unit/lack of personal space; and,

(c) Presence of residents exhibiting frequent aggression on the dorm creating a hostile or aversive environment.

(4) Resident interaction style factors for consideration include:

(a) Restriction or control exerted over others; and,

(b) Coerciveness.

f. The rationale for the bed assignment determination will take into consideration whether the resident is a low, moderate, or high risk for aggression, and any interventions or protective factors must be documented as part of the rationale.

(1) For Risk Variables and Diagnostic or Symptom factors, interventions could include:

(a) Medication by injection if resident refuses oral medication;

(b) Court ordered medication if medications are refused; and,

(c) Emergency treatment orders if the resident is an imminent threat to the safety of self or others.

(2) For environmental factors:

(a) Residents reacting to crowding may need to be moved to a different dorm or observation area until behavior improves.

(b) Create positive reinforcement incentives for time in a dayroom, comfort room or area less densely occupied as a reward for good behavior or consider developing a behavioral intervention.

(c) Individuals with a history of frequent aggression, particularly a history of targeting vulnerable people (elderly, intellectually disabled, young, etc.), must be housed in an area away from vulnerable residents.

(d) Consider the mix of residents on the dorm. Gross (2005) suggests that involuntary civilly committed residents are the most aggressive, followed by residents with incompetent to proceed (ITP) commitments, followed by residents with not guilty by reason of insanity (NGI) commitments, and followed by voluntary civilly committed residents. Also, residents with mood disorders or mixed episodes are more frequently aggressive than residents with psychosis; residents with antisocial personality disorder or mixed personality and a mood disorder are more aggressive than residents without a personality disorder; residents with borderline personality disorder alone are more aggressive than residents with borderline personality disorder and a mental illness. Separate residents or break up hostile mixes as indicated.

(3) For interaction style factors:

(a) Offer the resident choices for completion of necessary activities (e.g., make bed or do laundry first) to allow residents to have a sense of control yet complete the required tasks of daily living.

(b) Consistently follow policy, procedure, and protocols such that requests for resident action are part of an established process instead of perceived as demands from select staff. Maintain professional boundaries at all times. Consistent application of policy, procedure, and protocols can also decrease confusion and frustration of residents by limiting inconsistencies across shifts, teams, dorms, pods or units.

(c) Identify positive primary reinforcers for prosocial behavior and build upon them to facilitate trusting relationships, as well as compliance.

(d) Residents posing an active threat to the safety of others would be encouraged to participate in therapeutic rehabilitation/engagement activities or motivational interviewing. Residents posing an active threat to the safety of others would not be permitted to attend extra activities considered a privilege (e.g., dances), which should be promoted as activities for residents with prosocial behavior.

(4) Risk rating considerations:

(a) The likelihood of actual physical aggression increases as risk assessment scores increase.

(b) Residents rated as a high risk for aggression require increased frequency of assessment in order to manage the aggression.

g. Once a bed assignment determination is established or changed, at the next team meeting the resident's response to placement and interventions previously used to alleviate behaviors should be documented, including the rationale for the continued bed assignment and interventions as well as any changes in factors or determinations.

h. The Recovery Team leader or designee will verify bed assignments are reviewed by Teams according to this operating procedure during internal audit review.

6. Transgender Residents.

a. All residents will be treated in a courteous and professional manner while maintaining safety and security. Discrimination or harassment of any kind based on sexual orientation or gender identity is strictly prohibited.

b. If possible, a resident identified as gender nonconforming will be housed with those of that resident's expressed gender. Private showering and dressing times or areas will be provided. The facility will allow the resident to express his/her identified gender, as long as it does not violate the facility's contraband and dress policies. However, prior to placement on a dorm/pod of that resident's expressed gender, a thorough risk assessment on a case by case basis will be conducted. Upon placement, a review of the resident's placement by his/her treatment/recovery team should occur at least monthly. No resident meeting the definition of this operating procedure may be segregated from other residents for reasons related to gender identity without approval from the facility's Medical Director and Hospital Administrator.

c. A resident will not be placed on an increased level of observation unless warranted due to clinical, behavioral, medical, or admission status.

7. Training. Staff must be trained on bed assignment procedures during new employee or discipline specific training and at least annually thereafter.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JACQUELINE A. YOUNG
Director, State Mental Health Treatment Facilities, Policy and Programs

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

Term "private entities" changed to "state contracted facilities;" journal article citation added to paragraph 3j; and other minor editing.

RISK ASSESSMENT GUIDE FOR RESIDENTIAL BED ASSIGNMENTS

Resident's Name:	Resident Number:

BROSET VIOLENCE CHECKLIST (BVC)

ITEMS/SCORING	ITEMS/SCORING	ITEMS/SCORING	SCORING/RISK OUTCOME
Confusion: appears obviously confused and disoriented ☐ 0 ☐ 1	Physical Threats: definite intent to physically threaten another person ☐ 0 ☐ 1	Attacks on Objects: e.g., throwing an object, banging/ smashing windows, kicking, banging or head-butting an object, smashing furniture ☐ 0 ☐ 1	TOTAL SCORE = _____ RISK ☐ 0 = Low ☐ 1 – 2, Moderate, employ preventive actions ☐ >2, High, employ preventive actions and make plans how to manage physical aggression
Boisterousness: e.g., behavior that is loud (e.g., slams doors, shouts) ☐ 0 ☐ 1	Verbal Threats: e.g., a verbal outburst with the intent to intimidate or threaten another person ☐ 0 ☐ 1	Irritability: easily annoyed or angered, unable to tolerate the presence of others ☐ 0 ☐ 1	

DYNAMIC APPRAISAL OF SITUATIONAL AGGRESSION (DASA)

ITEMS/SCORING	ITEMS/SCORING	ITEMS/SCORING	SCORING/RISK OUTCOME
Irritability ☐ 0 ☐ 1	Impulsivity ☐ 0 ☐ 1	Unwillingness to follow directions ☐ 0 ☐ 1	TOTAL SCORE = _____ RISK ☐ 0 = Very Low ☐ 1 – 3, Moderate, preventative actions indicated ☐ = or > 4, High, preventive actions indicated, immediate intervention ☐ 6 – 7, Very High, may pose an imminent risk for aggression, immediate intervention
Sensitivity to perceived provocation ☐ 0 ☐ 1	Angered when request denied ☐ 0 ☐ 1	Negative attitudes ☐ 0 ☐ 1	
		Verbal threats ☐ 0 ☐ 1	

ADDITIONAL RELEVANT INFORMATION, ESTIMATED RISK, AND ACTIONS EMPLOYED

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Signature:_____ Date:_____ Time:_____